



Flexible Spending Account (FSA) Enrollment Form

I. Account Holder Profile Information

First Name:		Last Name:		SSN:
Date of Birth:		Email Address:		
Mailing Address Line 1:				
Mailing Address Line 2:				
City:		State:		Zip:
Home Phone:			Cell Phone:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single			Employer:	

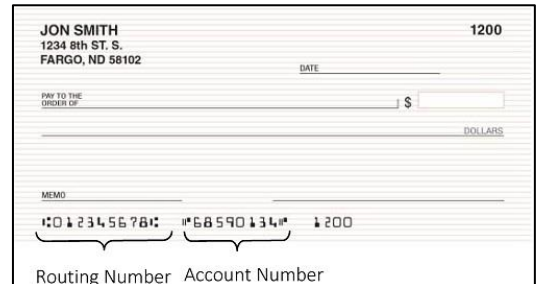
II. Election

I authorize my employer to make the following pre-tax deductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event such as marriage, divorce, death, or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn't eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck.

Effective Date:		1 st Payroll Deduction Date:		
Number of Payrolls this plan year: <input type="checkbox"/> 52 <input type="checkbox"/> 26 <input type="checkbox"/> 24 <input type="checkbox"/> 12 <input type="checkbox"/> Other # _____				
Healthcare Standard FSA	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____		
Healthcare Limited FSA <i>(Only if enrolled in a HSA)</i>	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____		
Dependent Care Account	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____		

III. Direct Deposit Setup

Bank Name: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Account Number:		
Routing Number:		
Address:		
City:	State:	Zip:



IV. Debit Card

A Debit Card will automatically be issued in the account holders name and shipped to the address above. Once the enrollment is processed it should arrive within 10-14 days.

Note: To issue separate debit cards to any dependents 18 years of age or older, please complete the following section.

Name:	DOB:	SSN:	Relationship:
Name:	DOB:	SSN:	Relationship:

V. Authorization

Signature _____ Date _____	Employer Authorization: _____
**Please be sure to return this form to your employer for approval. **	