Please return this form to your Employer by12:00 PM on May 18, 2018

****Please note that if you are enrolling in a HSA Qualified High Deductible Plan you are not eligible to enroll in a Health Care FSA****

Enrollment Form: Flexible Spending Account(s)

Plan Year: July 1, 2018 – June 30, 2019

GENERAL INFORMATION:

Employee Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Date of Hire (MM/DD/YYYY): _____

FLEXIBLE SPENDING ACCOUNTS:

☐ I hereby elect to participate in the Flexible Spending Accounts

Effective date of coverage: **July 1, 2018**

The first payroll deduction will be on **July 5, 2018**

	Annual Election	Pay Schedule	Per Pay Period Deduction
Health Care FSA	_____	☐ weekly ☐ bi-weekly ☐ monthly	_____
Dependent Care FSA	_____	☐ weekly ☐ bi-weekly ☐ monthly	_____

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

_____ _____

Employee Signature Date

WageWorks is the administrator of your Plan.
Please return this form to your Employer.