eflexFSA

Print Form

FSA Enrollment Form

Employee Information *(Please print clearly.)*

Social Security # _____ Date of Birth _____

Employer Name _____ Dept/Location _____

First Name _____ Middle Initial _____ Last Name _____

Employee Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ email _____

Help us go green! If provided, we'll use your email as our primary method of contact.

Employment Date _____ (Month Day Year) Plan Effective Date _____ (Month Day Year)

Employer Information *(Employer to complete the information below.)*

Date of 1st Payroll Deduction _____ (Month Day Year)

Employee Plan Effective Date _____ (Month Day Year)

☐ 12-Month Plan Year

☐ Short Plan Year

Employee Elections *(Employee to complete the information below)*

A. Group Medical Premiums *(If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.)*

	Annual Election	# of Payroll Deductions		$ Per Pay Check
B. Health FSA	$_____	/ _____	=	$ _____
C. Dependent Daycare FSA	$_____	/ _____	=	$ _____
D. Individual Health Policy	$_____	/ _____	=	$ _____
E. Limited Purpose FSA	$_____	/ _____	=	$ _____
F. Administration Fee (if any)	$_____	/ _____	=	$ _____
TOTALS	$_____	/ _____	=	$ _____

☐ My employer offers the claims auto download through my medical carrier. I would like to take advantage of this service.

☐ No, I do not want to enroll. If a change in status occurs, I may have the right to enroll in the plan at that time (if my employer's plan allows).

☐ Yes, I want to enroll. The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes. Please see the Summary Plan Description for details.

Signature _____ Date _____

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Direct Deposit Information *(Please complete this section if you are a new eflex customer or if your bank account information has changed in the past year. You don't need to complete this section if you had direct deposit in the last plan year and your bank account information hasn't changed.)*

Employee Information

Employee Name: _____ Social Security Number: _____

Home Telephone: _____ Alternate Telephone (work/cell): _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Name of Employer: _____

Bank Account Information

Bank Name: _____

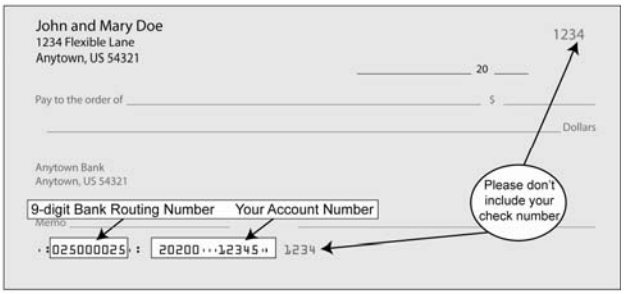
Bank Address: _____

City: _____ State: _____ ZIP: _____

Name on the Account: _____

Routing and Transit Number: _____

Account Number: _____



IMPORTANT: Please provide a voided check for each account listed above. We will not process without a voided check. Do not use a deposit slip as the number could be invalid.

Authorization

I authorize reimbursements from my Section 125 FSA, Dependent FSA, Individual Health Premium, Limited Purpose FSA, or my Section 105 Health Reimbursement Arrangement to be sent to the financial institution named above to be deposited in the designated account.

In the event funds are deposited erroneously into my account, I authorize my Section 125/105 administrator to debit my account(s) not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.

Signature: _____ Date: _____

Please fax, email, or mail completed form with a voided check to your HR/Personnel Department.

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