*All fields required.* ***Please Print!***

Flexible Spending Account (FSA)

# Employee Participation and Compensation Reduction Agreement

**For** _____ **for Plan Year** _____ **to**_____.
(Company Name) (Start Date) (End Date)

**Employee Name:** (First) _____ (Middle Initial) _____ (Last) _____

**Social Security No.:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

**Home Address:** (number and street) _____

(city, state, zip)_____

**Phone number:** ( _____ ) _____ This is my: ☐ Work / ☐ Home / ☐ Cell

**Email Address:** _____

☐ Check this box if you are renewing your enrollment and any of your information above has changed in the last 12 months.

**Benefit Cards** - ***Keep Your Old Card!*** If your Plan includes a benefit card (MasterCard) and you already have a card ***keep your card***. Your new funds will be "reloaded" on your card. Each card is good until the expiration date printed on the card.
**Direct Deposit** – To have your manual claim reimbursements deposited directly to your checking or savings account please obtain a copy of the Direct Deposit Authorization form and submit it with this Employee Participation Agreement.

## Election of Health Flexible Spending Account

☐ I **elect** to participate in the **Health Flexible Spending Account (FSA)** for the Plan Year indicated above.

I want to elect a total amount of $ _____ for the new plan year. I certify that the funds in my Health FSA account will only be used to reimburse qualified out-of-pocket healthcare expenses that are incurred by me and my dependents, and expenses not covered by insurance or other reimbursement plans.

☐ I **decline** to participate in the health FSA for this Plan Year. *(Office use only: _____ / pay pd.; Freq: _____ )*

## Election of Dependent Care Flexible Spending Account

☐ I **elect** to participate in the **Dependent Care Flexible Spending Account (DCA)** for the Plan Year indicated above.

I want to elect a total amount of $ _____ for the new plan year. I certify that the funds in my Dependent Care FSA account will only be used to reimburse qualified dependent care expenses. [The maximum amount per calendar year is the lesser of: (1) $5,000 for married filing jointly or $2,500 for married filing separately; (2) your spouse's total annual compensation; or (3) one-half of your total annual compensation. If you are single, the maximum amount is $5,000.]

☐ I **decline** to participate in the DCA for this Plan Year. *(Office use only: _____ / pay pd.; Freq: _____ )*

**Please indicate the frequency of your pay periods.** If you are uncertain, please ask your Human Resources Representative.
☐ Weekly ☐ Semi-monthly (24 cycles/yr) ☐ Monthly (date:_____) ☐ Bi-weekly (26 cycles/yr)
☐ Annually (month/date:____/____) ☐ Other: (specify): _____.

By signing below, I understand that:

- I am authorizing my employer to reduce my compensation by the amount(s) specified above.
- If I have enrolled in employer-sponsored insurance benefits my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars, and if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect my taxable income will automatically be adjusted accordingly.
- I have received and read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations that I have under the Plan.
- If either I or my legal spouse actively contributes to a Health Savings Account (HSA) that it may affect my eligibility to elect a Flexible Spending Account (FSA). I will contact my human resources or Savers representative if I need further information.
- I cannot change or revoke any of my elections or this compensation agreement at any time during the Plan Year unless I have a recognized change in status and my election is consistent with such change.
- Any funds that are not used during the Plan Year or within the specified Grace Period, if this option is offered under my employer's Plan, will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.
- Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections for the following Plan Year. In order to elect a new FSA plan for the new Plan Year I must complete and return a new election form at that time.
- If I cease my employment with the Employer my participation in the Health Flexible Spending Account will be subject to the continuation coverage rules of COBRA, provided that my Employer is required to offer COBRA.

_____ _____
**Employee's Signature (*Required*)** **Date**

***HR Department:*** *For mid-year new-hire, change-in-status, etc., please specify eligibility date:* _____ *and date of first payroll deduction:* _____.

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