Flexible Spending Account Enrollment Form

RETURN THIS COMPLETED TO YOU TO YOU EMPLOYER.

STEP 1 Participant Information

Employer

Date of Birth (mm/dd/yyyy)

First Name

Last Name

M.I.

Social Security Number

Mailing Address

City

State

Zip

Telephone

Email Address

Date of Hire

STEP 2 Flexible Benefit Plans

NOTE: Enter effective date of coverage:

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year will be forfeited. Expenses/claims must be incurred during the Plan Year or Grace Period/Run-Out Period in order to be eligible for reimbursement. See the Plan Highlights for more details.

Benefit Type	Per Pay Period	# of Pay Periods		Annual Election
Health Care Reimbursement	$		=	$
Dependent Care Reimbursement	$		=	$

Please note: I understand the benefits debit card is to be used exclusively for Qualified Expenses as defined by the plan in which I participate. If I use the benefits debit card for an expense that is not a Qualified Expense, I understand that I am indebted to my employer and must repay the full amount of the non-qualified expense. Payment on non-qualified expenses may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.

Waive Participation in FSA
(Check the box below to waive FSA)

☐ **I hereby elect *Not* to participate in the Flexible Spending Account.**

STEP 3 Participant Certification & Signature

I hereby elect to participate in the Flexible Benefits Plan and therefore authorize my Employer to reduce my wages on a pretax basis during each payroll period in the following amount. I understand this election will be in effect for only the current Plan Year. I understand I must complete each year.

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 Plan Highlights.

I understand that I must submit a claim and appropriate substantiating documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Benefit Plan for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Participant Signature

Signature Date (mm/dd/yyyy)

For employer use only: Employers sponsoring the FSA may submit this form through the Employer Upload Site located at https://www.mymidamerica.com/file-upload/employers/. Select *Employer File Upload*, then *Census.*