# Flexible spending account Enrollment/change form

## With employer contribution

Attention: ASO Flex MS 2260
1231 East Beltline NE • Grand Rapids, MI 49525-4501 • Fax to 616.942.5242 | *PH-enrollment@priorityhealth.com*

**I am completing this form for (check all that apply):**

☐ FSA enrollment ☐ Limited FSA enrollment (for use with an HSA health plan) ☐ Dependent care enrollment ☐ Name/address change ☐ FSA election change

**Section 1 — Employee information**
Complete each item in this section.

| | | | |
|---|---|---|---|
| Employee last name | First name | Middle | Social Security number **required for FSA enrollment* - - |
| Street address | City | State | Zip code / Phone |
| Employer name | Group number | Gender ☐ Male ☐ Female | Birth date: / / |
| Date of hire: / / | Email address | | |

**Section 2 — Dependent information (required for all dependents eligible for FSA reimbursements)**
Complete each item with your spouse and dependent(s) information.

| | Social Security number | Last name | First name | M.I. | Gender | Birth date | Relationship to employee |
|---|---|---|---|---|---|---|---|
| **1 – Spouse** | | | | | ☐ Male ☐ Female | | |
| **2 – Dependent** | | | | | ☐ Male ☐ Female | | |
| **3 – Dependent** | | | | | ☐ Male ☐ Female | | |
| **4 – Dependent** | | | | | ☐ Male ☐ Female | | |

Please attach a separate document listing additional dependents and their information.

**Section 3 — Flexible spending arrangement enrollment and pre-tax elections**
Check the appropriate box for enrollment or to decline enrollment. Enter your total annual contribution amount in the box marked "Annual election amount." Your annual maximum may not exceed the lesser of your earned income, spouse's earned income or employer's maximum amount.

| | |
|---|---|
| **Employer contribution into health care FSA:** See your employer materials for election maximum<br>☐ **Yes** – My employer will contribute to my health care FSA (Please place employer contribution amount to the right)<br>☐ **No** – I am not yet eligible for employer health care FSA contributions (leave box to right blank) | Annual election amount<br>$ |
| **Employee contribution into health care FSA:** See your employer materials for election maximum<br>☐ **Yes** – I wish to participate in the employee contributions to my health care FSA (please place election amount to the right)<br>☐ **No** – I decline to participate in employee contributions to an health care FSA | Annual election amount<br>$ |
| **Total** (Please total employer and employee contribution together and place in box to the right.) | Annual election amount<br>$ |
| **Dependent care FSA:** Annual maximum up to $5,000 (however, your elected amount cannot be greater than you or your spouse's earned income OR $2,500 if you are married but file a separate tax return from your spouse)<br>☐ **Yes** – I wish to participate in the dependent care account (Please place election to the right) No - I decline to participate in the dependent care account<br>☐ **No** – I decline to participate in the dependent care account | Annual election amount<br>$ |

continued >

## Section 4 — Pre-tax premium elections

On a separate enrollment form, I have enrolled in one or more health care coverages (medical, dental, vision) and I have received materials showing my share of the contributions for such coverage. I understand that an amount equal to such contributions will be deducted on a pre-tax basis from my paychecks to pay for the coverages that I elected. I understand that my contributions to premium may be automatically increased or decreased to coincide with changes made to my coverage premium(s).

## Section 5 — Employee certification

Read this section carefully then sign and date the form. Make or keep a copy for your records and submit the completed form to your payroll, personnel or benefits office.

As evidenced by the signature below:

- I certify that I will not seek reimbursement elsewhere for expenses that the health care FSA reimburses. Or, if I have been reimbursed for any amount that has also been paid or reimbursed by another health plan, I will arrange to repay that amount to my health care FSA.
- I understand any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws.
- I understand that the deduction(s) listed above will be in effect for the plan year and cannot be revoked or changed unless I experience a change in my family status or termination of my spouse's employment, consistent with federal regulations.

| Employee signature | Date |
|---|---|
| | |

## Section 6 — Employer information

Indicate any changes in family status such as marriage, birth or adoption or divorce.

**Employer health care arrangement contribution (if applicable):**

| | | | |
|---|---|---|---|
| **Change in status** | Reasons for additions or changes<br>☐ Marriage ☐ Birth ☐ Child by legal adoption/guardianship (attach copy of court form)<br>☐ Other _____ | | Effective date of change<br>/ / |
| | Reaon for deletions or changes<br>☐ Marriage of dependent ☐ Divorce ☐ Death ☐ Lost eligibilty<br>☐ Other _____ | | Effective date of change<br>/ / |
| **Employee election change** | Health care FSA | Old annual election amount<br>$ | New annual election amount<br>$ |
| | Dependent care account | Old annual election amount<br>$ | New annual election amount<br>$ |

| Employer signature | Date |
|---|---|
| | |