HRC TOTAL SOLUTIONS

Flexible Spending Accounts Enrollment Form

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Additional dependent Visa cards: Recipients must be 18 or older

Name:_____ DOB: _____ SSN: _____ Relationship: _____

Name:_____ DOB: _____ SSN: _____ Relationship: _____

Email Address for All Correspondence: _____ 1st Payroll Deduction Date: _____

Company Name: _____ EE Effective Date on plan: _____

I authorize my employer to make the following pre-tax reductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event; which includes within my immediate dependents, marriage, divorce, death or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn't eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck.

(PLEASE CHECK THE ACCOUNTS YOU WANT TO ENROLL IN AND FILL IN THE AMOUNTS BELOW)

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

❑ **Regular FSA** ❑ **Limited Purpose FSA** (For HSA Participants)

Annual Election for Medical, Dental, and Vision for my family: $ _____

Check the number of pay periods this plan Year: ❑ 52 ❑ 26 ❑ 24 Other: _____

The Amount per Pay Period Reduced from my check for this Account $ _____
(Divide the Annual Election by the Number of Pay Periods Above)

(I understand that my election is based on the eligible expenses allowed by the IRS. Any expense that I have included that is not eligible for reimbursement, will not be paid; any question on eligibility will be determined by my employer.)

❑ DEPENDENT CARE ACCOUNTS

Annual Election for Dependent Care Expenses: $ _____

Check the number of pay periods this plan Year: ❑ 52 ❑ 26 ❑ 24 Other: _____

The Amount per Pay Period Reduced from my check for this Account $ _____
(Divide the Annual Election by the Number of Pay Periods Above)

I understand that my election is based on the eligible expenses allowed by the IRS. These expenses must meet the following requirements:

1. Dependent Care expenses must be incurred during the plan year for the care of a dependent age 12 or younger.
2. Dependent Care expenses may be incurred for a spouse or other tax dependent that is mentally or physically incapable of caring for them self.
3. The expense needs to be incurred during the time that you and your spouse (if applicable) are gainfully employed.
4. The Dependent Care provider must be either a babysitter that cares for the dependent in or outside of your home or a day care center that meets state and local requirements, such as, a pre-school, summer day camp, and after school programs. Any form of dependent care provider you use needs to provide you with a tax ID or social security number.
5. Expense cannot exceed your taxable compensation, or your spouse's actual earned income.

I understand that I cannot change my election during the plan year unless I have a qualifying event and claims must be incurred within the plan year that I'm seeking reimbursement for/from. If I do not utilize all of the monies set aside into this account, then I will forfeit this amount. My social security benefit may be reduced by this election. I will have up to 90 days (or up to the length of time allowed by my employer) beyond the end of the plan year to submit claims that I incurred during the plan year.

Employee Signature: _____ Date: ____/____/_____ Accepted By Employer: _____

Please be sure to return this form to your Employer for approval

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