Employer Use Only:
___Re-enrollment
___New Enrollment
Effective Date:_____
1st Payroll Deduction Date:_____

Flexible Spending Account (FSA) Data Collection Worksheet

*=Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

Employee ID Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

*City

*State

*Zip

Email Address

Day Telephone

*Date of Birth (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Gender (M/F)

*Marital Status (Married/Single)

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. **Note:** Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Plan Type (If enrolled in an HSA, you are not eligible to enroll in the Medical FSA.	**Medical FSA** Annual Limit:$2,850	**Dependent Care Account** Annual Limit:$5,000
Annual Election:	$	$
Participant Effective Date (mm/dd/yyyy):		
Per Pay Period Amount (to be deducted each pay period):	=	=
Pay Frequency (please check one):	Monthly	Bi-Weekly

Step 4: Authorization

I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

*Participant Signature

*Date

Please complete and submit this form to Kris Akut, Benefits Coordinator.