FlexSave of America Enrollment Form

Social Security Number: _____/_____/_____

Last Name:_____ First Name:_____ M.I.: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone #: _____ Email Address: _____

Date of Birth: _____/_____/_____

Please list all dependents and spouse (if applicable) who will be covered under your plan(s). Dependent children up to the age of 26 are eligible for benefits through the end of the tax year of their 26th birthday. Please do not request new FlexCards if you do not need them. If cards are set to expire, you will receive new cards automatically.

Relationship	Last Name	First Name	M.I.	SSN Only include soc #'s for new dependents	DOB Only include DOB for new dependents	Issue Card Y/N*
Spouse						
Child						
Child						
Child						
Child						

Benefit Account	Annual Election
FSA	$
DCA	$
Limited-FSA	$

FSA (medical) $2750 MAX

DCA (child care) $5000 MAX

Limited FSA (dental/vision only) $2750 MAX available only to those enrolled in the High Deductible Health Plan through the College)

I hereby apply for the options listed above. I authorize my employer to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in effect throughout the plan year, unless I have a change in family status. I also understand that any unspent money remaining in my account(s) at the end of the plan year will be forfeited. I agree that if my employer pays out of FlexSave Spending Accounts, whether by inadvertence or design, more than I was entitled to receive, my employer may withhold amounts from my wages until the improperly paid portion has been recovered. My submission of this form authorizes my employer to reduce my compensation to recover amounts improperly paid from my Health Care Account.

Date: / / Signature: _____

_____

Bargaining Group

Please return this form to Human Resources.