Print Form

2024 PLAN YEAR

Flexible Spending Account Enrollment Form

Follow these easy steps:

1. Complete all entries on this Enrollment Form. Please print.
2. Sign and date this form.
3. Submit it to your Human Resources Department

For Employer Use	
Date of Hire (MM/DD/YYYY)	
Benefits Effective Date (MM/DD/YYYY)	

Personal Information

Employee Name (last name, first name)		Social Security Number	
Street Address (cannot be PO Box)		City, State, Zip Code	
Mailing Address (if different)		City, State, Zip Code	
Day Time Phone Number		Email Address	
Date of Birth (MM/DD/YYYY)		Enrollment Status ☐ New enrollment	☐ Re-enrollment

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Health Flexible Spending Account (FSA)		Dependent Care Assistance Plan (DCAP)	
☐ Select FSA	☐ Decline FSA	☐ Select DCAP	☐ Decline DCAP
I. Annual Contribution (Not to exceed IRS limits*) $3,200 for 2024		I. Annual Contribution (Maximum Contribution: $5,000)	
II. Number of regular pay periods		II. Number of regular pay periods	
III. Contribution per pay period (I divided by II)		III. Contribution per pay period (I divided by II)	

Authorization and Certification

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Funds left in my Dependent Care Account at the close of the plan year will be forfeited. Funds left in my Health Flexible Spending Account may be forfeited, per plan rules. See plan documents for more details.

I will receive a ConnectYourCare Payment Card to access funds in my account. I certify that:

- The card will only be used for eligible medical and/ or dependent care expenses.
- Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

Employee Signature _____ Date _____

*Health FSA contributions are limited by the IRS. The limit is per person; a married couple may each contribute up to the specified limit.