SelectAccount℠

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

July 01, 2017 – June 30, 2018

Location Name: _____

Employee Information

Last Name: _____ First Name: _____ MI _____

SSN#: _____ Primary Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Date of Birth: _____ / _____ / _____

Account Information: Effective Date: Beginning July 1st or 1st of the month following date of hire.

1. Medical Flexible Spending Account: ☐ **Waive participation**

IRS plan year maximum $2,600

☐ I want to contribute a total of $ _____ during this plan year to my Medical Flexible Spending Account.

I understand this amount will be deducted from my payroll throughout the plan year.

Do you or your spouse have a Health Savings Account (HAS) with another administrator?

☐ No ☐ Yes: Your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met. Contact SelectAccount to remove the limit when your deductible is met.

2. Dependent Care Flexible Spending Account ☐ **Waive participation**

IRS plan year maximum: $5,000 ($2,500 if married but filing separate tax returns)

☐ I want to contribute a total of $ _____ during this plan year to my Dependent Care Flexible Spending Account.

I understand this amount will be deducted from my payroll throughout the plan year.

Debit Card

Once enrolled into flex, you will automatically be issued a debit card to use for reimbursement for your medical flexible spending account. Your debit card(s) will be mailed to the account holder address on file at SelectAccount. **Do not destroy previous card(s) unless you are issued a new card. Medical crossover is no longer available. If you were previously in medical crossover, you will automatically be issued a debit card.**

Employees new to medical flexible spending account: Please complete the section below:

Debit Card Signature - I certify that such expenses will not be eligible for benefit payment by any other insurance carrier and that such expenses will not be manually submitted by me to this or any other reimbursement account when I use my debit card. I understand that any debit card transaction using funds other than HSA may be subject to proof of purchase documentation upon request by SelectAccount. Failure to respond will result in cancellation of the debit card and I must reimburse the plan with after-tax dollars. I also understand that by requesting a debit card for my dependents, I am authorizing them to have access to information regarding their specific debit card transactions

Debit Card Signature: _____ **Date:** _____

Print Name:

Enrollment Form Signature

I have reviewed the above elections and understand that my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end Plan Year may be forfeited.

Participant Signature: _____ **Date:** _____

Questions? Contact Julia Sandsness, Diocese of Winona at (507) 858-1268 or email benefits@dow.org or Leader Services: (651) 662-2320 or (888) 460-4013.

Location Office to Complete: **Number of months this employee works during plan year:** _____

Effective Date: _____

Benefit Office to Complete: **Monthly amount billed to location):** Medical _____ Dependent Care _____