SelectAccount℠

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

July 01, 2015 – June 30, 2016 **Location Name:** _____

Employee Information

Last Name:_____ **First Name:**_____ **Middle Initial:** _____

SSN#:_____ **Phone:** _____ **Date of Birth:**_____/_____/_____

Street Address:_____ **City:**_____

State:_____ **Zip Code:** _____ **Email Address:**_____

Account Information

Medical Flexible Spending Account: Plan year maximum: **$2,550**

Effective Date: **Beginning of plan year July 1st or 1st of the month following date of hire.**

☐ 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 pay throughout the plan year.

☐ Waive Participation

Do you or your spouse have a health savings account 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.

Dependent Care Flexible Spending Account: IRS Maximum: **$5,000.00 ($2,500 if married but filing separate tax returns)**

Effective Date: **Beginning of plan year July 1st or 1st of the month following date of hire.**

☐ 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 pay throughout the plan year.

☐ Waive Participation

Debit Card / Crossover

Debit Card / Crossover:
Once enrolled into the flex you will be automatically issued a debit card to use for reimbursements. You can decline the debit card and elect medical crossover below.

☐ **Debit Card:** You are automatically enrolled

☐ **Medical Crossover:** Medical Crossover allows your health plan to automatically submit claims to Select Account for reimbursement. (See the "Tips for using electronic reimbursement called Crossover" document in your packet). If you or any of your covered dependents have more than one health plan (private or Medicare) please do not enroll in Crossover.

Payroll Schedule

Indicate your payroll schedule:

☐ Monthly on the _____of each month ☐ Twice monthly on the _____and_____of each month

☐ Bi-Weekly (indicate first pay date after July 1, 2015): _____

Signature

I have reviewed the above elections and understand 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 accounts at the end of the Plan Year may be forfeited.

Signature:_____ **Date:** _____

Send Completed Forms To: Diocese of Winona – Mail: PO Box 588 Winona, MN 55987 / E-mail: severs@dow.org / Fax: (507)454-8106
Questions? Contact Sara Evers, Diocese of Winona: (507)858-1268 / severs@dow.org or Leader Services: (651)662-2320 or 1-888-460-4013

Office Use Only: Effective Date: _____ Payroll Type: _____ Amount Per Pay: _____