



FSA Enrollment Form

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

EMPLOYER USE
Please complete for mid-year enrollments

- Weekly Semi-Monthly (twice a month)
- Bi-Weekly (every other week) Monthly

PREMIUM CONTRIBUTIONS

- I elect to participate (check all that apply)
- Health Insurance Group Life Insurance Disability Insurance Dental Insurance
- HSA Contributions Vision Insurance Other(s)_____
- The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.
- I elect NOT to participate

MEDICAL REIMBURSEMENT ACCOUNT

- I elect to participate \$_____ annually (may not exceed employer limit of \$_____)
- Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments
- This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (see page 2)
- I elect NOT to participate

DEPENDENT CARE ACCOUNT

- Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium co