Carroll County

csONE BENEFIT SOLUTIONS

FSA ENROLLMENT FORM

INSTRUCTIONS:

1. Please complete, sign and date this form. (* = Required Fields)
2. Return it to your supervisor or HR Department.

Account Holder Information (Please print):			
*Name (Last, First, MI)	*Social Security Number	*Date of Birth	*Hire Date
*Address	*City	*State	*Zip
*Home Phone Number ( )	*Daytime Phone Number ( )	*Email Address	* # Pay Periods

Dependent Information			
Name	Social Security Number	Date of Birth	Relationship

Election Agreement

I agree to have my gross salary reduced, in accordance with section 125 of the Internal Revenue Code, to contribute to the Flexible Spending Account in the amount indicated below. My employer can make these contributions on my behalf. This salary reduction arrangement will continue until:

- I terminate employment with my present employer; or
- I have a change in family status (e.g. marriage, divorce, birth or adoption of a child, death of a spouse or dependent, or change in my or my spouse's employment status) that makes it necessary for me to modify this agreement: or
- The end of the plan year covered by this agreement. For future plan years, I will have the opportunity to modify this agreement; or
- My employer terminates, suspends, or modifies this plan.

I understand that if I do not return this form to my employer, they will assume I do not want to participate in the Employee Reimbursement Account program.

I understand that if my participation should end due to a qualifying event, prior to the plan year's end, I am able to submit eligible claims to my Flexible Spending Account that were incurred prior to the end date of my participation.

I understand that contributions to the Flexible Spending Account can only be used for eligible expenses within each plan. I further understand that if I do not use the funds in my Employee Reimbursement Account during the plan year, those funds will not be paid to me; they will be forfeited. I also understand that reimbursement expenses cannot be claimed as credits or deductions on my personal tax return.

Direct Deposit Setup	
*Bank Name	*Account Type ☐ Checking or ☐ Savings
*Routing Number	Illustration of Bottom of Check
*Account Number	Routing Number Account Number

FSA Type	**Annual Election**	**# Pay Periods**	**Amt Each Pay Period**
Health FSA Use for health expenses ex. copays, deductibles, prescriptions	$_____	_____	$_____
Dependent Care FSA Can be used for child care expenses for children under 13. $5,000.00 max or $2,500.00 if married filing separately	$_____	_____	$_____

Payroll Details	
Pay Schedule ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other: _____	Salary Reduction Begins with payroll dated _____ and continues through _____

In the event our group does not pass the necessary nondiscrimination tests, I authorize my employer to make any necessary reductions to my election in order to conform with the nondiscrimination rules.

***Employee Signature:** _____ **Date:** _____