isolved Benefit Services

FSA Enrollment*

Plan year beginning _____ Ending _____ Check one: ☐ New enrollment ☐ Re-enrollment

Employer _____ Division (if applicable) _____

Employee name _____ Soc. Sec. No. _____

Date of birth _____ Home address _____

City _____ State _____ Zip _____ Email _____

Payroll Frequency ☐ Weekly (52) ☐ Biweekly (26) ☐ Semimonthly (24) ☐ Monthly (12) ☐ Other

Date of hire _____ Effective date _____

Paycheck deductions start on _____ Number of deductions in the Plan year _____

Benefit Election Authorization or Waiver

Enter the annual amount of your allocation(s) for the Plan Year to the account(s) of your choice and divide by the number of paychecks you receive during the Plan Year to arrive at the amount of your salary reduction each paycheck.

Benefit Elections: **Annual Election**

A. Dependent Care Flexible Spending Account (FSA) $ _____

B. Health Care Flexible Spending Account (FSA) $ _____

Total Authorized Pre-tax Salary Reductions $ _____

☐ Waiver of Participation in Health FSA and Dependent Care FSA

After careful consideration, I have chosen not to participate in the FSAs for the current Plan Year.

C. Premium Payment (Pre-Tax) **Per Pay Period $** _____

Contributions to the employer-sponsored benefit plan(s)

☐ Waiver of Participation in Pre-tax Premium Payment

After careful consideration, I have chosen not to participate in the pre-tax premium portion of the Plan

By sign ng bel ow, I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified.
- I understand that I am not permitted to change my elections during the Plan Year unless the change is on account of and consistent with current recognized IRS regulations and change in status events.
- I also understand that unused account balances in m y Dependent Care and Health FSAs at the end of the Plan Year or Plan's grace period are subject to forfeiture, based on applicable IRS l aw and regulations and Plan design.

Employee Signature _____ Date _____

*Return this enrollment form to your employer.

isolved Benefit Services has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your FSA coverage

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