# Flexible Spending Account Enrollment Form

**Please check one of the following:**

☐ Open Enrollment for New Fiscal Plan Year:

☐ New Employee: _____

☐ Change of Contribution/Payroll Deduction:

Event / Reason for Change: _____

Date of first paycheck affected:_____

**(Indicate New Annual Election and per Pay Period Contribution Amount in Section 2)**

**TRISTAR Benefit Administrators**
**PO Box 65887 - West Des Moines, IA 50265**

Shaded Area Completed by Employer

| Group Number | Location | Employee Classification | Effective Date |
|---|---|---|---|
| 41050 | | | |

## 1. Employee Information

| | | | |
|---|---|---|---|
| Last Name / First Name / Middle Initial | | Date of Birth (mm/dd/yyyy) | Gender: Male ☐ Female ☐ |
| Home Mailing Address | | Social Security Number | Home Telephone No. |
| City / State / Zip | | Marital Status | Date Employed (mm/dd/yyyy) |
| Enrollee's Employer's Name: City of North Liberty | | Email Address for Correspondence | |
| Spouse's Name | | Date of Birth (mm/dd/yyyy) | Gender: Male ☐ Female ☐ |
| Child's Name | | Date of Birth (mm/dd/yyyy) | Gender: Male ☐ Female ☐ |
| Child's Name | | Date of Birth (mm/dd/yyyy) | Gender: Male ☐ Female ☐ |
| Child's Name | | Date of Birth (mm/dd/yyyy) | Gender: Male ☐ Female ☐ |
| Child's Name | | Date of Birth (mm/dd/yyyy) | Gender: Male ☐ Female ☐ |

## 2. Medical Reimbursement Plan

**MEDICAL REIMBURSEMENT PLAN — CHOOSE ONE BELOW**

☐ **General-Purpose Health FSA** ☐ **Limited Health FSA (Vision / Dental / Preventive Care)**

**Your Election Amount** $ _____ ÷ _____ = $ _____

Total Annual Before-Tax Dollars / Number of Pay Periods / Contribution / Pay Period

☐ I do not elect to participate in the Medical Reimbursement account

☐ This is a change. New annual election $_____ New per paycheck contribution $_____

## 3. Dependent Care Reimbursement Plan

**DEPENDENT CARE REIMBURSEMENT PLAN**

Maximum Allowable amount if Single, Head Of Household or Married, Filing Joint Return: $5,000 per Plan Year

Maximum Allowable amount if Married, Filing Separate Return: $2,500 per Plan Year

**Your Election Amount** $ _____ ÷ _____ = $ _____

Total Annual Before-Tax Dollars / Number of Pay Periods / Contribution / Pay Period

☐ I do not elect to participate in the Dependent Care Reimbursement account

☐ This is a change. New annual election $_____ New per pay period contribution $ _____

## 4. Designate Your Beneficiary

I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible benefits spending account should be made payable to the undersigned.

Beneficiary:_____ Relationship:_____

## 5. Premium Payment Plan Election

☐ Yes, I authorize my employer to reduce my salary before taxes by the employee contribution amount, as designated by my employer, to cover the premium for my employer-sponsored health insurance plans in which I have elected to enroll.

☐ No , I do not authorize my employer to reduce my salary before taxes by the employee contribution amount, as designated by my employer, to cover the premium for my employer-sponsored health insurance plans in which I have elected to enroll.

## 6. Read and Sign

My signature on this form certifies that I have received and read the printed material explaining my employer's flexible benefits program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (e.g., marriage, divorce, birth, or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.

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