HealthEquity

Enrollment Form: Flexible Spending Account(s)

GENERAL INFORMATION

Employee Name: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Plan Start Date: 7/01/2023 **Plan End Date:** 6/30/2024

Benefit	Per Pay Period	# Pay Periods	Annual Election	Max Election
Healthcare FSA	**$**		**$**	$3,050
Dependent Care FSA	**$**		**$**	$5,000

(Day care expenses incurred during employment hours)

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects me or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description.

I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

☐ I hereby elect to participate in the Flexible Spending Account.

☐ I hereby elect NOT to participate in the Flexible Spending Account.

_____ _____

Employee Signature Date