Flexible Spending Benefit (FSA, DCA, IND) Enrollment Form*

CLEARLY print the following information required for enrollment.

Employer:	**Employee Effective Date**	/ /

Questions regarding data provided may result in unexpected delays in processing.

Employee Last Name*	Employee First Name*	MI

Social Security Number* _ _ _ - _ _ - _ _ _ _	Date of Birth* / /	*Circle F M	Daytime Phone (_ _ _) _ _ _ - _ _ _ _

Home Address*	City*	State*	Zip Code*

Email Address	Department

*Please refer to your Implementation/Renewal paperwork to verify benefit eligibility. KBA will enroll individuals assuming qualification have been met in order for this form to be generated.

Participant acknowledges the following by signing below: Pursuant to my Employer's Flexible Benefits Plan ("Plan"), I elect to have my salary reduced by the total pre-tax amount specified below. I authorize my Employer to apply amounts listed toward plan benefits listed with the totals indicated on this form.

Individual Premium Flexible Spending Account Expenses

#of deductions remaining as of effective date_____
Individual Premium Contributions per pay peridod $ _____
Individual Premium Plan Annual Total(this should equal the number of deductions times the per pay) $_____

Health Care Flexible Spending Accounts Expenses

#of deductions remaining as of effective date_____
Health Care FSA Contributions per pay peridod $ _____
Annual Health Care FSA Total $_____
(I understand if my spouse participates in a Health Savings Account (HSA) at his/her employer, I may not be able to participate in this general Health Care FSA.)

Dependent Day Care Flexible Spending Account Expenses

#of deductions remaining as of effective date_____
Dependent Day Care FSA Contributions per pay peridod $ _____
Annual Health Care FSA Total $_____

☐ **No, I do not wish to participate in my Employer sponsored Flexible Spending Accounts.**

III. I UNDERSTAND AND AGREE THAT:

- I cannot change or revoke my election until the next Plan Year unless my Status changes (as defined in my Employer's Plan). I understand my benefit elections may not be reduced below the amount that has been taken pre-tax as of the date of the status change.
- Any funds remaining in my reimbursement accounts at the end of the plan year will be forfeited by IRS regulations to my employer.
- If my employment terminates for any reason, I understand expenses must be incurred and submitted within the time frames set out in the Plan.
- I understand that any receipt I submit must be for an eligible expense incurred by me, my spouse or my qualified dependent(s) during the applicable Plan Year.Before the first day of each Plan Year, I will be offered the opportunity to modify my elections for the following Plan Year.
- My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan if my Employer in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue code or the regulations there under.
- By signing and using the Flex Card, if so provided by my employer, I accept responsibility that all Card transactions will be solely for qualified expenditures incurred within the Plan Year. Each time I present the Card for payment, I will sign a receipt evidencing that the expense has been incurred and reaffirming that it is a qualified expenditure that has not been reimbursed, is not reimbursable from any other source, nor will any reimbursement be sought from any other source. Upon request, I will immediately submit any required documentation and/or transaction detail. I understand that if I use the Card for purchases other than qualified expenditures, I have violated this Agreement and my obligations under my Employer's Plan. I understand that, upon notification, I must immediately re-pay the expense to the Account and that my Card may be immediately suspended or revoked for such failure to comply. Should repayment for ineligible expenses not be remitted in a timely manner, I authorize my employer to deduct the amount from my paycheck.*

* Subject to state/local laws

Employee Signature_____**Date**_____