



# Flexible Spending Account Enrollment Form

Name: \_\_\_\_\_ Plan Year: \_\_\_\_\_

Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Hire Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Work Location: \_\_\_\_\_

Address: \_\_\_\_\_ Payroll Frequency:

\_\_\_\_\_  weekly  monthly

\_\_\_\_\_  bi-weekly  other: \_\_\_\_\_

FLEXIBLE SPENDING ACCOUNT (FSA) ELECTIONS		
Options:	Annual maximum:	Fill in the annual amount you elect for payroll deduction:
Medical FSA	\$ _____	\$ _____ per year
Dependent Care FSA	\$5,000 (\$2,500, if married, filing separately)	\$ _____ per year

## AUTHORIZATION (check one):

**ELECT BENEFITS:** I have received the Summary Plan Description (SPD) which summarizes the benefits available to me under the FSA. I have read the Other Terms and Conditions, and I agree to comply with them. I authorize a reduction in my pay for the payments required to fund the FSA.

**DECLINE BENEFITS:** The benefits for this program have been explained and offered to me. I elect not to participate in an FSA.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## OTHER TERMS AND CONDITIONS

I understand and agree that:

- The benefit elections that I've made are effective for the entire plan year and cannot be changed or revoked unless I experience a change of status as set forth in the plan documents.
- I am responsible for paying for the contributions to my FSA. I authorize my employer to deduct these amounts from my payroll compensation (on a pre-tax basis) throughout this plan year. If I have a qualifying event that changes my benefit status, my compensation automatically will be adjusted to reflect the increase or decrease that results from my change in status, as provided in the Internal Revenue Code.
- The Plan Administrator may reduce or cancel my pre-tax elections or otherwise modify this agreement in the event the Plan Administrator believes it advisable in order to satisfy the Internal Revenue Code.
- The reduction in my cash compensation under this agreement is in addition to any reductions under other agreements or benefit programs maintained by my employer.
- Any amounts that are not used during the plan year (or during any extension period, if allowed by law) to provide benefits will be forfeited, and unused funds may not be paid to me in cash or used to provide benefits in a later plan year.
- If I have elected to participate in the Dependant Care FSA, I certify that I am (and if married, my spouse is) actively at work, a full-time student or actively seeking work. I understand that if I no longer meet the qualifications for the Dependant Care FSA, my contributions will be forfeited and my participation will cease.
- BlueCross BlueShield of South Carolina will not automatically process FSA payment for allowable FSA expenses that are not processed by my medical and/or dental plan. I will submit a claim form for these types of expenses.

**THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME. IN EFFECT, IT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, AND IT REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.**