EMPLOYER USE ONLY	
Effective Date:	1st Payroll Deduction:
HR Signature:	
Mail to: Att: Eligibility Dept. PO Box 953, Charleston WV 25323 Fax to: 304.720.4934 Email to: CDSEligibility@healthplan.org	

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

It's easy to save money with a Flexible Spending Account (FSA). Just pick one or both of the options below. You will pay the same amount for health care and/or dependent care expenses initially - but you'll receive savings when you submit receipts for expenses that are then reimbursed from your tax-free FSA. The health care FSA shields your out-of-pocket health care expenses from taxes. The dependent care FSA does the same for qualified childcare or other dependent care expenses. You select an amount to be shielded, increments of which are set aside from your paychecks during the year. **FSA funds can only be used for your eligible dependents claimed on your yearly IRS tax returns.**

EMPLOYEE INFORMATION				
Company Name:				
Employee Name:			Social Security #:	
Address:				
City:	State:	Zip:	Date of Birth:	
Home Phone:	Cell Phone:		Email:	
FSA PLAN YEAR	From:	To:		

Dependent Care FSA

☐ I elect to participate. _____ (Amount Per Pay) x _____ (# of Pay Periods 24) = _____ (Total Amount $5000 annual maximum, $2500 if married filing separately)

☐ I elect to waive participation.

Authorization:

I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible change in status. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Any unused amounts remaining in my account at the end of the plan year will be forfeited. However, I will have a specified period of time (90 days) after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or employment period.

Employee Signature:_____ Date: _____