

Flex Spending Account Enrollment Form

Plan Year: _____ First Contribution Date: _____ Hire Date: _____

Employer Name:				Location/Division/Branch:			
Employee Name:				Social Security Number:			
Phone Number:				Email Address:			
Street Address							
City:			State:		Zip Code:		
Date of Birth: (mm/dd/yyyy)			☐ Direct Deposit* – Complete Direct Deposit Authorization on page 2				

*Reimbursement Check have a per check fee, so set up Direct Deposit to avoid any fees!

Enter the HCFSAs and/or DCFSAs election amounts, even if \$0, then sign, date, and return form to Employer.
Your cost of insurance premiums is calculated based on the benefits you have elected and is withheld pre-tax. There is no fee for this.
If you do not want to have your premiums withheld pre-tax, you must notify payroll in writing prior to the plan start date¹

Flexible Spending Accounts

Are you contributing to a Health Savings Account (HSA)? ☐ Yes ☐ No
(This is a bank account used with HDHP and LPFSA)

Account Type	Annual Election Amount
Health Care Flexible Spending Account (FSA) See Employer for Plan Year maximums – <u>Not eligible to participate if you are contributing to an HSA</u>	\$ _____
Limited Purpose Health Care Flexible Spending Account (LPFSA) Those in the HSA can participate for Dental, Vision, and non-Deductible expenses ONLY	\$ _____
Dependent Care Flexible Spending Account (FSA) Plan Year maximum is \$7,500. See Guide for important information	\$ _____

See your Employer to determine what, if any, fee is applicable if you participate in an FSA. Fee is pre-tax as well

Election and Salary Reduction Agreement

I hereby authorize my employer to reduce my cash compensation as indicated above for the Plan Year following the date of this agreement. This total amount will be divided by the number of pay periods and may be adjusted to meet the annual election amount if a pay cycle is missed. The funds can be accessed for reimbursement by submitting claims to the plan for eligible expenses. (I have elected to have my cost of premiums withheld tax free – however I understand those premiums are not reimbursable. The Payroll Department will calculate my contribution based on the benefits I have enrolled in).

I understand that this election form, for both the FSA categories as well as my eligible group insurance premiums, cannot be revoked or changed during the plan year, unless there is a qualifying change in status (e.g. marriage, divorce, death of a spouse/child, birth or adoption of a child, or termination of employment - see plan documents) which justifies the revocation or change.

I understand that if any unused contributions remain in the account at plan year end & subsequent grace period, the IRS "use it or lose it" rule applies, and those funds will be forfeited. I understand that all expenses must be incurred during the plan year to be considered eligible (see plan documents to see if plan has optional extension). Incurred is the date the services were rendered, not the date the expense may have been paid or billed. I know that each year I have the option to change my elections during the Open Enrollment Period (OEP). If I do not submit changes, in writing, during the OEP, my elections *may* remain the same for the new plan year (see plan documents for your plan specifics). Eligible insurance premium changes each year are automatically withheld pre-tax. I can opt out of having my eligible insurance premiums withheld pretax, if I submit such request to payroll prior to the beginning of the plan year or before first deductions are taken.

Participant's Signature _____

Date _____

☐ If you do not want your eligible insurance premiums withheld pre-tax, initial box and return form to Employer. The Premium Conversion Plan is administered by your employer and simply deducts your share of the premiums on a pre-tax basis.

Flex Spending Account Reimbursements

To ensure prompt and accurate processing of your request, complete this form and either:

- Return to your Employer
- E-fax it to (951) 346-4244
- Secured Email to customerservice@PAYPROtpa.com
- Mail it to: PAYPROtpa, P.O. Box 5040, Riverside, CA 92517

Employer Name:

Employee Name:

SSN:

☐

TO ENROLL IN DIRECT DEPOSIT check box and complete section

Bank Name

Routing Number

Account Number

Authorization – I hereby authorize PAYPROtpa and my Bank, as indicated above, to initiate entries into my designated account. I verify that the Account number and Routing number listed above are true and accurate.

If my Bank is ever notified by PAYPROtpa that funds, to which I am not entitled to, have been erroneously deposited into my account, I authorize my Band to return such funds to PAYPROtpa.

Signature

Date

☐

TO CHANGE YOUR BANK and/or DIRECT DEPOSIT check box and complete top section and this section

Bank Name

Routing Number

Account Number

Authorization – I hereby authorize PAYPROtpa and my Bank, as indicated above, to initiate entries into my designated account. I verify that the Account number and Routing number listed above are true and accurate.

If my Bank is ever notified by PAYPROtpa that funds, to which I am not entitled to, have been erroneously deposited into my account, I authorize my Band to return such funds to PAYPROtpa.

Signature

Date

☐

TO CANCEL DIRECT DEPOSIT check box and complete top section and this section

My signature below indicates that I wish to cancel my direct deposits. I understand that a 30-day notice is necessary, prior to my cancellation date

Signature

Date

To send a secure email to protect your information, start the subject line with [SECURED].

Example: [SECURED] Enrollment Form