

FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

Thereby request a debit card. If you would also like a debit card for your spouse/dependent, please print their name and SS#, below:	This form is submitted for: Enrollment Change Termination Qualifying Event			
Employee's Address: City:	SECTION A: EMPLOYEE INFORMATION			
SECTION B: SPENDING ACCOUNTS The maximum allowable annual contributions are: Dependent Care Reimbursement Account (DCAP) S5,000 maximum/Or, 25,500 if married, filing separately Health Care Reimbursement Account (HCRA) Health Care Reimbursement Account (HCRA) S3,050 maximum I request the following benefits be deducted from my pay on a Pre-Tax Basis: Dependent Care Reimbursement Account (HCRA) S(Annual) \$(Per Pay Period) Health Care Reimbursement Account (HCRA) S(Annual) \$(Per Pay Period) Health Care Reimbursement Account (HCRA) S(Annual) \$(Per Pay Period) SECTION C: FSA DEBIT CARD I hereby request a debit card. If you would also like a debit card for your spouse/dependent, please print their name and SSH, below: Spouse/Dependent's Name Spouse/Dependent's SS# SECTION D: AUTO PAY Auto Pay — when a health claim is fully or partially unpaid, HealthComp's system will automatically check the participant's flexible spending account, and if it is eligible to be reimbursed, it will pay out of that account. This saves the participant from having to wait fo an EOB in order to submit a physical claim for reimbursement out of their flexible benefits account. Yes, I do want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do return	Employee's Name:	Social Security #:	Employee's Email:	
SECTION B: SPENDING ACCOUNTS The maximum allowable annual contributions are: Dependent Care Reimbursement Account (DCAP) S5,000 maximum/Or, \$2,500 if married, filing separately Health Care Reimbursement Account (HCRA) \$3,050 maximum I request the following benefits be deducted from my pay on a Pre-Tax Basis: Dependent Care Reimbursement Account (DCAP) \$ (Annual) \$ (Per Pay Period) Health Care Reimbursement Account (HCRA) \$ (Annual) \$ (Per Pay Period) SECTION C: FSA DEBIT CARD I hereby request a debit card. If you would also like a debit card for your spouse/dependent, please print their name and SS#, below: Spouse/Dependent's Name Spouse/Dependent's SS# SECTION D: AUTO PAY Auto Pay - when a health claim is fully or partially unpaid, HealthComp's system will automatically check the participant's flexible spending account, and if it is eligible to be reimbursed, it will pay out of that account. This saves the participant from having to wait fo an EOB in order to submit a physical claim for reimbursement out of their flexible benefits account. Yes, I do want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) Complete the Authorization Agreement below for Direct Deposit. Your signature is required to process this request and you will need to attach a voided blank check if poing into your checking account; or, if going into your savings account, write your bank's routing numbe and your savings account number. I hereby authorize HealthComp Administrators to make my reimbursement(s) into my: Checking Savings (Routing #) (Account #) This authority is to remain in full force and effect until HealthComp has received written notification from me of its termination in suct time and such manner as	Employee's Address:			
The maximum allowable annual contributions are: Dependent Care Reimbursement Account (DCAP)		City:	State: Zip:	
The maximum allowable annual contributions are: Dependent Care Reimbursement Account (DCAP)	SECTION B: SPENDING ACCOUNTS			
Dependent Care Reimbursement Account (DCAP) \$ (Annual) \$ (Per Pay Period) Health Care Reimbursement Account (HCRA) \$ (Annual) \$ (Per Pay Period) SECTION C: FSA DEBIT CARD Thereby request a debit card. If you would also like a debit card for your spouse/dependent, please print their name and SS#, below: Spouse/Dependent's Name	\$5,000 maximum/Or, \$2,500 if married, filing separately Health Care Reimbursement Account (HCRA)			
Section C: FSA DEBIT CARD S	I request the following benefits be deducted from m	y pay on a Pre-Tax Basis:		
Health Care Reimbursement Account (HCRA) S (Annual) S (Per Pay Period)	Dependent Care Reimbursement Account (DCAP)	\$ (Annual) \$	(Per Pay Period)	
Thereby request a debit card. If you would also like a debit card for your spouse/dependent, please print their name and SS#, below:	Health Care Reimbursement Account (HCRA)			
Spouse/Dependent's Name	L.			
SECTION D: AUTO PAY	☐ I hereby request a debit card. If you would also like a debit card for your spouse/dependent, please print their name and SS#, below:			
Auto Pay — when a health claim is fully or partially unpaid, HealthComp's system will automatically check the participant's flexible spending account, and if it is eligible to be reimbursed, it will pay out of that account. This saves the participant from having to wait fo an EOB in order to submit a physical claim for reimbursement out of their flexible benefits account. Yes, I do want to elect Auto Import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto Import SECTION E: DIRECT DEPOSIT AUTHORIZATION Complete the Authorization Agreement below for Direct Deposit. Your signature is required to process this request and you will need to attach a voided blank check if going into your checking account; or, if going into your savings account, write your bank's routing number and your savings account number. I hereby authorize HealthComp Administrators to make my reimbursement(s) into my: Checking Savings (Routing #) (Account #) This authority is to remain in full force and effect until HealthComp has received written notification from me of its termination in such time and such manner as to afford HealthComp and my financial institution a reasonable opportunity to act on it. Signature Date SECTION F: DECLARATIONS I hereby request participation in the above plan. I also certify the above information to be correct and true to the best of my knowledge. The reimbursement expenses for DCAP or HCRA will be submitted for me and my eligible dependents. I also understand that any amounts not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan document provisions and tax laws. I further understand that the deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status. Employee's Signature Date		Spouse/Deper	ndent's SS#	
spending account, and if it is eligible to be reimbursed, it will pay out of that account. This saves the participant from having to wait fo an EDB in order to submit a physical claim for reimbursement out of their flexible benefits account. Yes, I do want to elect Auto Import (Note: You cannot elect this feature if you elect the FSA Debit Card Option) No, I do not want to elect Auto Import SECTION E: DIRECT DEPOSIT AUTHORIZATION Complete the Authorization Agreement below for Direct Deposit. Your signature is required to process this request and you will need to attach a voided blank check if going into your checking account; or, if going into your savings account, write your bank's routing number and your savings account number. I hereby authorize HealthComp Administrators to make my reimbursement(s) into my: Checking Savings (Routing #) (Account #) This authority is to remain in full force and effect until HealthComp has received written notification from me of its termination in such time and such manner as to afford HealthComp and my financial institution a reasonable opportunity to act on it. Signature Date SECTION F: DECLARATIONS I hereby request participation in the above plan. I also certify the above information to be correct and true to the best of my knowledge. The reimbursement expenses for DCAP or HCRA will be submitted for me and my eligible dependents. I also understand that any amounts not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan document provisions and tax laws. I further understand that the deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status. I hereby decline participation in the above plan. Employee's Signature Date Date For Office Use Only:	SECTION D: AUTO PAY			
I hereby request participation in the above plan. I also certify the above information to be correct and true to the best of my knowledge. The reimbursement expenses for DCAP or HCRA will be submitted for me and my eligible dependents. I also understand that any amounts not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan document provisions and tax laws. I further understand that the deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status. I hereby decline participation in the above plan. Employee's Signature	an EOB in order to submit a physical claim for reimbout Yes, I do want to elect Auto Import (Note: Yes, I do not want to elect Auto Import Note: Yes, I do not want to elect Auto Import SECTION E: DIRECT DEPOSIT AUTHORIZATION Complete the Authorization Agreement below for Diattach a voided blank check if going into your check and your savings account number. I hereby authorize HealthComp Administrators to make (Routing #) (Account #) This authority is to remain in full force and effect untime and such manner as to afford HealthComp and Signature	ursement out of their flexible ben You cannot elect this feature if you Direct Deposit. Your signature is re king account; or, if going into your ake my reimbursement(s) into my) Intil HealthComp has received wri my financial institution a reasona	efits account. u elect the FSA Debit Card Option) equired to process this request and you will need to r savings account, write your bank's routing number Checking Savings itten notification from me of its termination in such ble opportunity to act on it.	
knowledge. The reimbursement expenses for DCAP or HCRA will be submitted for me and my eligible dependents. I also understand that any amounts not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan document provisions and tax laws. I further understand that the deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status. I hereby decline participation in the above plan. Employee's Signature		the state of the s	······································	
For Office Use Only:	knowledge. The reimbursement expenses for understand that any amounts not used for eligi current plan document provisions and tax laws. cannot be revoked unless I experience a change	DCAP or HCRA will be submitted gible expenses incurred during the control of the	ed for me and my eligible dependents. I also e plan year will be forfeited in accordance with	
•	Employee's Signature	Date		
Final Action Control C		Porticipation Effective Date:	# of Payrolls	