(800) 442-7247
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FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

This form is submitted for: ☐ Enrollment ☐ Change ☐ Termination ☐ Qualifying Event _____

SECTION A: EMPLOYEE INFORMATION

Employee's Name: _____ Social Security #: _____ Employee's Email: _____

Employee's Address:

_____ City:_____ State:_____ Zip:_____

SECTION B: SPENDING ACCOUNTS

The maximum allowable annual contributions are:

- Dependent Care Reimbursement Account (DCAP) ➥ $5,000 maximum/Or, $2,500 if married, filing separately
- Health Care Reimbursement Account (HCRA) ➥ $2,850 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 an additional debit card my 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 for 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 mentioned plan as completed on the preceding page. 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** _____

For Office Use Only:

Employer:_____ **Participation Effective Date:**_____ **# of Payrolls Remaining** _____