EBS can help:

Employee Benefit Systems Third Party Administration Services

Flexible Spending Account Enrollment Form

Personal Information

☐ **Open Enrollment** ☐ **New Hire** **Hire Date:** _____ **Effective Date:** _____

Employer Name: _____ **Date of Birth:** _____

Participant Name: _____ **Social Security Number:** ___ - ___ - ____

Address: _____ **City, State, Zip:** _____

Email: _____ **Phone:** _____

(all notifications are sent via e-mail)

☐ I hereby elect **NOT** to participate in the Flexible Spending Account for this Plan Year. *(Skip to premium contributions section)*

Flexible Spending and Dependent Care Agreement

☐ **General Purpose (all qualifying medical expenses)** **OR** ☐ **Limited Purpose (vision and dental expenses only)**
(Select if you, your spouse, or dependents make contributions to a Health Saving Account (HSA) or receive HSA contributions elsewhere)

- **Medical Reimbursement Account**
  Maximum medical per year $ _____
  $ _____ (Per Pay) x _____ (#Pays/Year) = $ _____ (Annual Election)

- **Dependent Care Reimbursement Account**
  $ _____ (Per Pay) x _____ (#Pays/Year) = $ _____ (Annual Election)

*Maximum Dependent Care year of $2,500 if married filing separately or $5,000 if single or married filing jointly, if more than $2,500 is elected, my signature on this agreement, certifies I am single or married filing a joint income tax return with my spouse.

Direct Deposit Authorization

☐ I hereby authorize Employee Benefit Systems to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This authorization shall remain in force until revoked by me. I have read and understand the information on this form regarding direct deposit of reimbursements.

This agreement is: ☐ On File ☐ New ☐ Change ☐ Cancel **Account Type:** ☐ Checking ☐ Savings

Account Number: _____ **Routing Number (9 digits):** _____

Name of Bank: _____ **Bank Phone:** _____

Premium Contributions

☐ I hereby elect to have my insurance premiums withheld on a pre-tax basis.
The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

Employee Authorization

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis to the plan, with such amount to be allocated among the benefits I selected above. I understand this election cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Plan Document. I certify that I will only claim reimbursement or use my flex debit card for eligible expenses for myself and/or qualified dependents. I further certify that these expenses will not be reimbursed under any other benefit plan.

I recognize that any expenses in excess of the maximum payment or ineligible expenses erroneously charged to my flex debit card represent an overpayment of my salary or wages and that I must repay my Employer that money immediately. My Employer may deduct any erroneous claims payments or flex debit card charges from my salary or wages. If my employment is terminated for any reason, the entire amount of any unpaid erroneous charges will be immediately due and payable and my Employer, without any other notice, may apply the debt against any amounts my Employer may owe me. Eligibility to participate ceases on the date of termination. I will need to submit manual claims for services incurred prior to the termination date during the run out period specified in the SPD (Summary Plan Description) in order to be reimbursed after the termination date. By accepting and using my flex debit card, I am agreeing to the terms and conditions contained in the Cardholder Agreement, including any amendments thereto, which will govern the use of the Card.

I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature: **Date:**

Contact Us

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EBS