Employee Flexible Spending Account (FSA) Enrollment Form

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PacificSource ADMINISTRATORS

* = required field

Section 1 - Employment Information – please print

Employer Name*				Division or Class	
Date of Hire *(Required for mid-year enrollees)*		FSA Effective Date*		First Deduction Date	
PSA Member ID *(if applicable)*		Employer's ID *(assigned by the employer to each specific employee)*		Number of hours worked per week	

Section 2 - Employee Information – please print

Last Name*		First Name*, MI			
Date of Birth*		SSN			
Mailing Address*					
City*		State*		ZIP*	
Primary phone		Secondary phone			
Email address *(If provided, notifications may be sent via email.)*					
Beneficiary Name and Relationship					

Section 3 - Premium Payment Component

☐ I agree to have my salary reduced on a pre-tax basis to pay the premiums offered by my employer for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance and/or other qualified benefits under Section 125 for myself and my eligible family members. *If my employer uses the evergreen method of enrollment; I will remain enrolled in the Premium Payment Component until I notify my employer in writing that I do not wish to have my share of the premium(s) deducted on a pre-tax basis.*

Section 4 - Flexible Spending Account Election Information

	Account (as offered)	Employee Pay Period Election	# of Pay Dates	Employee Annual Election	Account Information
DCAP Component	Dependent Care Expenses (DCE)	$	x	= $	Child care expenses (for dependents younger than13) and elder care expenses you incur while at work or school.
Health FSA Component	General Purpose Health FSA (HRE)	$	x	= $	Eligible medical, dental, vision, and preventive care expenses for yourself and your dependents.
	Limited Purpose Health FSA (LFSA)	$	x	= $	Eligible dental, vision, and preventive care expenses for yourself and your dependents. Employees contributing to a health savings account may elect this plan.
	Limited Scope Health FSA (LSFSA)	$	x	= $	Eligible dental and vision for yourself and your dependents. Employees ineligible for the group-sponsored medical plan may elect this plan.

☐ Check here if you or your dependents are enrolled (or plan to enroll) in a health savings account.
☐ Check here if you are not eligible (or won't be eligible) in your employer's group sponsored medical plan.

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Section 7 - Participant Authorization or Waiver – signature required

☐ **Participant Authorization**

I hereby certify the information provided on this form is correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the plan year may be forfeited in accordance with current Plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the plan year and cannot be revoked unless I experience a qualified change in status. I also understand that the reductions may correspondingly reduce my future Social Security benefits.

If I lose coverage under the Health FSA component as a result of a qualifying event (for example, termination of employment or cessation of eligibility because of a reduction in hours of employment), I may be entitled to elect coverage continuation under the Health FSA allowed by my employer's Plan. I understand that I cannot be forced to repay or voluntarily repay the employer for any amounts exceeding my Health FSA account balance.

☐ **Participant Waiver**

I do not wish to participate in the Plan, and waive enrollment for the Health FSA Component, DCAP Component, and Premium Payment Component. I understand that by refusing to participate, I will be unable to enroll this plan year unless my employer allows mid-year changes and I experience a qualifying event, in accordance to the IRS Code section 125, and submit the change within 30 days of the qualifying event.

Any person who, with an intent to knowingly defraud, files this application with materially falsified information or conceals material information, may be subject to criminal and civil penalties and PacificSource Administrators may cancel such person's membership and refuse to pay their claims.

*__Employee Signature:__ _____ __Date:__ _____

Employee: *Please return the original to your employer and retain a copy for your records.*

Employer: *Please audit the form, retain a copy for your records, and forward a copy to PacificSource Administrators or submit a spreadsheet electronically.*