

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM



PLAN INFORMATION	
EMPLOYER NAME _____	PLAN YEAR _____

EMPLOYEE INFORMATION		
FIRST NAME: _____	LAST NAME: _____	SOCIAL SECURITY NUMBER: _____
ADDRESS: _____	CITY: _____	STATE: _____ ZIP: _____
DAYTIME PHONE: _____	E-MAIL <sup>1</sup> : _____	DATE OF BIRTH: ____/____/____

ELECTION INFORMATION	
DEPENDENT CARE ACCOUNT	
<input type="checkbox"/> I hereby elect to participate in my employer's Dependent Care Flexible Spending Account which covers daycare expenses for my eligible dependents.	
\$ _____	\$ _____
*PER PAY PERIOD	ANNUAL
You can elect a household maximum of \$5000 per plan year if a single parent or if married and filing a joint return; \$2500 if married filing separately.	

HEALTHCARE SPENDING ACCOUNT		
<input type="checkbox"/> FULL FSA I hereby elect to participate in my employer's <b>FULL</b> Healthcare Flexible Spending Account which covers eligible medical, dental and vision expenses for me and my eligible dependents.  You can elect a maximum of \$ _____ per plan year.  \$ _____ \$ _____ *PER PAY PERIOD                      ANNUAL	Elect Full <b>OR</b> Limited	<input type="checkbox"/> LIMITED FSA I hereby elect to participate in my employer's <b>LIMITED</b> Healthcare Flexible Spending Account which only covers eligible dental and vision expenses for my eligible dependents and me.  You can elect a maximum of \$ _____ per plan year.  \$ _____ \$ _____ *PER PAY PERIOD                      ANNUAL  <small>If you or your spouse is participating in a Health Savings Account (HSA) you are restricted to a <b>Limited</b> Healthcare FSA.</small>
*Please check with your employer to determine the number of remaining payroll deductions if you enroll after the beginning of the plan year.		

REIMBURSEMENT INFORMATION
WageWorks, formerly Planned Benefit Systems will process your reimbursements according to the banking method we currently have on file, either check or direct deposit*. If you have never enrolled before, you will receive checks for your reimbursements. If you would like to make a change, you must submit a completed Reimbursement Authorization Agreement, which can be found on our website at <a href="http://www.pbs.us.com">www.pbs.us.com</a> . Your reimbursement method will remain in effect until an updated authorization form has been received and processed. To ensure your claim is paid using the method of your choice, it is advisable to submit changes well before submitting a request for reimbursement.
Direct deposits normally take 2 business days from the date of initiation. Bank holidays/weekends may affect when the deposit is credited to your account. Please contact your bank to verify all deposits are received. If you provide us with your email address we will inform you each time a Direct Deposit is initiated. Direct Deposits cannot be posted to debit or credit cards. Any direct deposit remitted by WageWorks and not rejected by your bank is deemed a valid reimbursement and will not be adjusted. There may be a \$25 fee to reissue lost/stolen checks.
*Direct deposit is not offered as an option under all plans. If your plan does not offer direct deposit, a check will always be issued for your reimbursements.

EMPLOYEE AUTHORIZATION
I have reviewed and understand the Terms and Conditions on the following page and as outlined in my employer's Summary Plan Description.
SIGNATURE: _____ DATE: _____
<b>***This form must be returned to your employer***</b>

FOR EMPLOYER USE ONLY		
DIVISION / LOCATION NAME: _____	TOTAL NUMBER OF PAYROLL DEDUCTIONS: _____	
DATE OF FIRST DEDUCTION: _____	DATE OF HIRE: _____	DATE OF ELIGIBILITY: _____

## **TERMS AND CONDITIONS**

<sup>1</sup> **Email:** By providing your email address, you agree to receive Employee Benefit Plan correspondence electronically. WageWorks does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, [help@pbs.us.com](mailto:help@pbs.us.com), to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the WageWorks Customer Service Department or by visiting our website at [www.pbs.us.com](http://www.pbs.us.com). WageWorks reserves the right to utilize an email address that may be provided to us by your employer.

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### **Qualifying Medical Care and Dependent Care Expenses**

I understand that reimbursement will be available only for "qualifying medical care expenses", as listed under Section 213, and "qualifying dependent care expenses", as listed under Sections 129 and 21 of the Internal Revenue Code, for me and my eligible dependents. These expenses must be incurred while I am enrolled in the Plan. I agree to notify the Plan Sponsor or WageWorks if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense for which I have been reimbursed that is not allowed under IRC Sections 213, 129 or 21. This includes purchases made with the PBS Benefits Card. I understand that claimed medical expenses cannot be reimbursed under the Healthcare FSA Plan if the expense has been or will be paid in the future by any other plan. I further acknowledge that I am responsible for keeping all receipts, verifying all eligible expenses claimed under the Plan and must submit such receipts to WageWorks for claims substantiation as requested.

### **Participation Rules**

I understand that eligibility, enrollment and benefits information is available from my Plan Sponsor or in the Plan's Summary Plan Description (SPD). I authorize payroll deductions for the benefits elected on this form. I understand that I cannot change or revoke this salary reduction agreement at any time during the plan year except when a Change in Status occurs. In that event, if I choose to change my plan elections, I must complete a Change Form within 30 days from such event. Please refer to the SPD for qualifying Change in Status events.

Any amounts remaining in the account(s) represented by this Election Form at the end of the Plan Year, past the claims filing deadline, will be forfeited to the Plan under the guidelines of the Internal Revenue Code. Expenses incurred prior to my plan enrollment date are not eligible for reimbursement.

This agreement is subject to the terms of the Plan Document as amended and in effect at the time, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws and revokes any prior election and salary reduction agreement relating to such plan.