WageWorks

Please return this form to your Employer

Enrollment Form: Flexible Spending Account(s)

Plan Start Date – Plan End Date
7/1/2023 6/30/2024

GENERAL INFORMATION:

Employee Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

Date of Hire (MM/DD/YYYY): _____

FLEXIBLE SPENDING ACCOUNTS:

☐ I hereby elect to participate in the Flexible Spending Accounts

☐ I hereby elect NOT to participate in the Flexible Spending Accounts

	Per Pay Period	# Pay Periods	Annual Election
Health Care FSA	$ _____	x _____ =	$ 0.00
Dependent Care FSA (Day care expenses incurred during employment hours)	$ _____	x _____ =	$ 0.00

Effective date of coverage: 7/01/2023 The first payroll deduction will be on _____ , 20____

My pay schedule is: ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

_____ _____

Employee Signature Date

WageWorks is the administrator of your Plan.
Please return this form to your Employer.