



# Flexible Spending Account (FSA) Enrollment Form

To elect to participate in your employer's YourWay FSA benefit, please complete this enrollment form and provide it to your employer's HR contact.

## 1 > Employer Information – Employer Use Only

Employer Name: <b>Hastings Public Schools</b>	Employer Number:
Withholding Schedule: <input type="radio"/> Weekly <input type="radio"/> Bi-Weekly <input checked="" type="radio"/> Semi-Monthly <input type="radio"/> Monthly	
Effective Date:	First Withholding Date:
Enrollment Type: <input type="radio"/> Open Enrollment <input type="radio"/> New Hire <input type="radio"/> Re-Enrollment	
Authorized Employer Signature:	

## 2 > Participant Information

Social Security Number:		Date of Birth:	
First Name:	Middle Initial:	Last Name:	
Address 1:		Address 2:	
City:	State:	Zip Code:	
Phone:			
Email:	<input type="checkbox"/> Check if you want to receive Plan communications via email.		

### FSA Benefit Elections (Please enter your FSA Elections below)

<input type="checkbox"/> Health Flexible Spending Account (FSA)	<input type="checkbox"/> Dependent Care Assistance Plan (DCAP)
Annual Election Amount: (Not to exceed IRS or Plan maximum) <b>\$ 3,050.00</b>	Annual Election Amount: (Not to exceed IRS or Plan maximum)
<ul style="list-style-type: none"><li>Elections must be made in advance of the start of the plan year and cannot exceed the IRS or Plan maximum contribution amount.</li><li>Election amounts will be deducted pretax.</li><li>Health FSA funds are available on the first day of the plan year for expenses incurred in the current plan year.</li><li>Dependent Care funds are available as the funds are withheld from your payroll.</li><li>All unused funds remaining at the end of the Plan's Runout or Grace Period (as applicable) will be forfeited back to your employer.</li></ul>	

### Authorization (Please acknowledge the below and sign)

<ul style="list-style-type: none"><li>I understand that all elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.</li><li>I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse and dependents. I also understand that daycare reimbursements will be available only for qualifying daycare expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.</li><li>I understand that I must submit a claim and appropriate documentation (e.g., explanation of benefits, itemized bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Account Plan for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.</li></ul>
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Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_