East End Health Plan

FSA PLAN
ENROLLMENT FORM

(Please print clearly)

PLAN YEAR BEGINNING _____/____/_____ ENDING _____/____/_____

Employee Information

Employer Name: _____ Group Number: _____

Effective Date (mm/dd/yyyy): _____/_____/_____ Hire Date (mm/dd/yyyy): _____/_____/_____

Employee Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy)	SSN (XXX-XX-XXXX)
			_____/_____/_____	_____-_____-_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address (optional): _____

Check one: ☐ New Enrollment ☐ Re-enrollment

Benefit Elections

	Annual Amount
Health Care Expense Account (Minimum Contribution $300 / Maximum Contribution $3,000)	$_____
Dependent Care Expense Account (Minimum Contribution $300 / Maximum Contribution $5,000)	$_____
TOTAL AUTHORIZED SALARY REDUCTIONS (Pre-Tax Salary Reductions)	$_____

Please note that a $4.20 per enrollee, per account, per month administrative service charge will be added to your election.

AUTHORIZATION: I understand that any salary reduction amounts not used by the end of the above plan year for eligible expenses incurred during the plan year will be forfeited by me in accordance with Section 125 of the Internal Revenue Code. I further understand that the reduction(s) specified above will be in effect for such plan year and can be revoked only if the election change is due and consistent with a change in my family status as defined in Section 125 (i.e. my marriage or divorce, death of my spouse or child, birth or adoption of a child by me, termination or commencement of my spouse's employment, change in employment status from part-time to full-time or from full-time to part-time by me or my spouse, me or my spouse taking an unpaid leave of absence, or significant changes in my health coverage or my spouse's health coverage attributable to my spouse's employment). I further understand that I will be subject to the terms and conditions of the Plan as defined in the Plan Document.

I hereby authorize my employer to reduce my salary each pay period on a pre-tax basis by the amount of my benefit election(s) specified above.

_____ _____

Employee Signature *Date*

_____

Authorized Employer Representative (print name)

_____ _____

Authorized Employer Representative Signature *Date*