FSA Enrollment Form

Employee Information

Last Name:_____ First Name: _____ M.I. _____

Email: _____

Address: _____

Social Security No.: _____

Home Phone No.: _____

DOB: _____ Gender: _____

Hire Date: _____ Effective Date: _____

Employee Elections/Premium Redirection Agreement

Plan Year July 1, 2018 – June 30, 2019	ANNUAL ELECTION	PER PAYROLL ELECTION 12 Mo (x 26) __ 10 Mo (x21)__
HEALTHCARE PRE TAX ELECTION Annual Maximum $1,000		
DEPENDENT CARE PRE TAX ELECTION Annual Maximum $5,000.00 or $2,500.00 If Married Filing Separately		

I agree to have my gross salary redirected, in accordance with Section 125 of the Internal Revenue Code, to contribute in the amounts indicated below. I understand that contributions to my reimbursement account(s) can only be reimbursed to me for eligible expenses incurred within each plan year. For example, funds in the Medical Reimbursement Account cannot be used for reimbursement of dependent care expenses. I further understand that if I do not use the funds in my reimbursement account(s) during the plan year, those funds cannot be paid to me, they will be forfeited.

Employee Signature: _____Date:_____

Direct Deposit Authorization

I have read and understand the information provided to me regarding direct deposit of reimbursements. I hereby authorize Bouchey & Clarke Benefits, Inc. to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This election shall remain in force until revoked by me.

Account Number_____ **Transit ABA Routing #** _____

Account type: ____ Checking ____Savings This agreement is ____New ____Change ____Cancel

Name of Bank _____ Bank Phone _____

DIRECT DEPOSIT INFORMATION

- The **Transit ABA Routing #** includes all the numbers between the colons. Be sure to include any zeroes at the beginning or end.
- The **Account Number** includes all the numbers after the second colon, except for the check number.
- ****A voided check or deposit slip is needed for verification and reference. Please attach to enrollment form.**

TERMS AND CONDITIONS

My election to contribute is subject to the acknowledgement and agreement of the following terms and conditions:

1. ACCEPTABLE FSA PLAN TERMS: I agree to abide by the terms, conditions and provisions of the FSA contained in Bouchey & Clarke Benefits, Inc.'s Plan Document. I acknowledge my right to examine the Plan Document. I acknowledge my right to examine the Plan Document or obtain a copy of it by giving reasonable advance notice and paying a fee.
2. RESPONSIBILITY: I acknowledge that the Internal Revenue Code permits me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my FSA elections and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other government taxing authority as a result of my requesting and receiving reimbursement from the FSA for disallowed expenses.
3. DEPENDENT CARE: I understand that the Internal Revenue Code prohibits me from claiming the Federal Child care Tax Credit for dependent care assistance expenses which are reimbursed to me by the FSA.
4. PLAN MODIFICATION: I have been informed that the FSA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the FSA according to their independent judgment and discretion without my consent or prior notice to me.
5. SOCIAL SECURITY: I choose to participate in the FSA despite my knowledge that my salary reductions elections may reduce my FICA withholdings (Social Security) and that this may reduce my Social Security benefits upon retirement.
6. FORFEITURE: I understand that I must claim reimbursement for eligible expenses incurred during the plan year within 90 days of the last day of the plan year. Otherwise, I understand that I will forfeit those reimbursements. I further acknowledge that I will forfeit all funds credited to my FSA accounts which are not reimbursed to me.
7. SEEK LEGAL ADVICE: I have been informed that my participation in the FSA will have tax and economic consequences to me and that before deciding to participate in the FSA, I should seek the advice of an attorney or tax consultant regarding the benefits, risks and limitations of the FSA.
8. IRREVOCABLE ELECTION: I understand I cannot change or revoke my election until the open enrollment period for the new Plan Year. I will be able to change my election if I have a change in status (qualifying event) as outlined in the Plan Document or Plan Provisions provided. The election change must be requested within 30 days of the event and must be on account of and consistent with the change in status.

Employee Signature: _____ Date: _____

Flexible Spending Plan is Administered by Bouchey & Clarke Benefits, Inc., PO Box 1616, Troy, NY 12181 518-720-8888

bouchey &clarke
BENEFITS, INC.