2018 - Flexible Spending Account Enrollment Form – Salaried

Follow these easy steps:

1. Complete all entries on this Enrollment Form. Please print.
2. Sign and date this form.
3. Submit it to your Human Resources Department

For HR Office Use
Date of Hire (MM/DD/YYYY)
Benefits Effective Date

Personal Information

Employee Name (last name, first name)	SMC Employee ID #
Street Address (cannot be PO Box)	City, State, Zip Code
Mailing Address (if different)	City, State, Zip Code
Daytime Phone #	Email Address
Date of Birth (MM/DD/YYYY)	Enrollment Status ☐ Re-enrollment ☐ New Enrollment
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Social Security Number	SMC Work Site

Flexible Spending Account (FSA) (For Medical Expenses)	Dependent Care Assistance Plan (DCAP) (Not for Medical Expenses)
☐ Select FSA ☐ Decline FSA	☐ Select DCAP ☐ Decline DCAP
I. Annual Contribution (Not to exceed IRS limits* $2650) $ _____	I. Annual Contribution (Maximum Contribution: $5000 $ _____
II. Number of regular pay periods 24	II. Number of regular pay periods 24
III. Contribution per pay period (I divided by II) *To be calculated by HR* $_____	III. Contribution per pay period (I divided by II) *To be calculated by HR* $_____

Certification

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Any funds left in my Flexible Spending and/ or Dependent Care Accounts at the close of the plan year will be forfeited.
- I will receive a ConnectYourCare Payment Card to access funds in my FSA account. I certify that:
- The card will only be used for eligible medical and/ or eligible dependent medical expenses.
- Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

_____ _____

Employee Signature Date