Lee County
Human Resources

FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

To enroll, complete the following information, sign the form, and return it to Human Resources. *To avoid processing delays, please complete all fields on the application and print clearly-*

Department: ____

Employee Name: ____ **SSN:** XXX-XX-________________

Employee Address/City/State/Zip code:_________________________**EmployeePhoneNumber:**____________________

EMPLOYEE'S FLEXIBLE SPENDING ACCOUNT ELECTION

Enrollment Reason (please circle one)**: New Hire / Open Enrollment / Other:** ______________________________

FSA Election Effective Date: ____________________

Payroll Frequency : Bi-Weekly

I understand the choices I have indicated above are IRREVOCABLE unless a "qualifying status change" occurs as defined by the Internal Revenue Service. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Service Code Section 125, if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for expenses are not filed within the required time-period. I understand if I am terminated, discharged or have my hours reduced to less than 30 hours per week, I will be automatically terminated from the plan. If termination from the plan occurs either voluntarily or involuntarily, or if I stop all contributions:

- No benefits will be paid for any expenses incurred for dependent care and/or medical services after the termination date and any plan contributions made after the termination date will be refunded, subject to taxation
- **Annual Elected FSA Amounts are deducted from two pay periods each month, which will consist of 24 deductions per year.**

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

☐ I hereby elect to participate in the following Flexible Spending Accounts:

☐ **HEALTHCARE FSA** (out-of-pocket medical, dental, vision, eligible over-the-counter expenses for you and your tax dependents)

Annual Limit Minimum Election: $600.00 **Annual Limit Maximum Election: $2,750.00**

_________________ Amount Per Pay Period X ____________________ 24 Pay Periods = ________________ Annual Election

☐ **DEPENDENT CARE FSA** (out-of-pocket day care expenses)

Annual Limit Minimum Election: $600.00 **Annual Limit Maximum Election: $5,000.00**

_________________ Amount Per Pay Period X ____________________ 24 Pay Periods = ________________ Annual Election

I hereby authorize Lee County to adjust my salary in accordance with the above elections. I have read and fully understand the rules both above and on the reverse side of this form governing this plan. If for any reason the information provided above should change, I will immediately notify my employer. I understand that falsification of any information on this application or my reimbursement forms may result in termination of my employment and will require full reimbursement by me of all benefits paid under this plan.

Employee Signature **Date**

TO BE COMPLETED BY THE EMPLOYER

Department/Location: ____

FSA Effective Date: ______________________________ FSA Payroll Contribution Start Date: ____________________________

Employer Signature: ____ Date: ________________________________