



**FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM**

**Company Name:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ Telephone: \_\_\_\_\_

Employee Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ Plan Year: \_\_\_\_\_ through \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Effective Date: \_\_\_\_\_

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay un-reimbursed medical and/or dependent care expenses with after-tax dollars.

**EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION**

**Medical Flexible Spending Account**

\$ \_\_\_\_\_ Maximum Annual Contribution      Per pay contribution \$ \_\_\_\_\_ Date of first payroll \_\_\_\_\_  
Annual contribution \$ \_\_\_\_\_ Number or remaining pays \_\_\_\_\_

**Dependent Care Spending Account**

\$ \_\_\_\_\_ Maximum Annual Contribution      Per pay contribution \$ \_\_\_\_\_ Date of first payroll \_\_\_\_\_  
Annual contribution \$ \_\_\_\_\_ Number or remaining pays \_\_\_\_\_

**I UNDERSTAND THAT:**

- (1)** My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.
- (2)** I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- (3)** The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

By signing this form I agree to the terms and procedures listed herein.

I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



ADDITIONAL CARDS (only applicable if your employer has chosen this option)

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meet the IRS eligibility guidelines below:

(1) For federal tax purposes, a spouse is defined as "... a person of the opposite sex who is a husband or wife." Same sex domestic partners are not considered spouses for purposes of FSA administration. A person residing in the employee's home, who the employee provides over half of their support, who is not the employee's spouse, under applicable state law and is not a family member, is considered a dependent under Internal Revenue Code 152(a) without regard to 152(b)(1), (b)(2), and (d)(1)(B).

(2) For federal tax purposes, a dependent includes any relative of the participant for whom the participant provides over half of their support for the calendar year. A relative includes children, parents, stepchildren, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be a certain age or infirmity; they need only to be persons for whom the participant has provided over half of their support.

Spouse Name: \_\_\_\_\_

Address to issue card: \_\_\_\_\_

Telephone: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

All dependents must be over the age of 18 in order to receive the AmeriFlex Convenience Card®.

Dependent Name: \_\_\_\_\_

Address to issue card: \_\_\_\_\_  
(if different from participant)

Telephone: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dependent Name: \_\_\_\_\_

Address to issue card: \_\_\_\_\_  
(if different from participant)

Telephone: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Each AmeriFlex Convenience Card® is issued for a term of three years. For you (the employee), your card will be automatically activated for each new plan year that you participate in one or more Flexible Spending Account(s). However, dependent cards do not automatically activate each plan year. For each plan year that you participate, you must notify AmeriFlex if you wish to have dependent cards reactivated for the new plan year. Upon expiration, AmeriFlex will automatically issue new cards to participants who re-enroll in the new plan year.

AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS

I, hereby, authorize AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my bank account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

Depository Name: \_\_\_\_\_ Account Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_  
(always nine digits)

SELECT ONE:  Checking Account  Savings Account

If you would prefer, please attach a voided check.

CHECK EXAMPLE		
⋮⋮ 23456789	⋮0000 123456	⋮1234
ROUTING NUMBER	ACCOUNT NUMBER	CHECK NUMBER

The authorization is to remain in full force and effect until the ADMINISTRATOR has received written notification from the employee named above of the termination in such time and in such manner as to afford the ADMINISTRATOR and DEPOSITORY a reasonable opportunity to act on it.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements in to the bank account provided two days after every processing date determined by your employer.

It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.