FLEXSAVE
Of America, Inc.
Consumer Driven Healthcare Solutions

FSA ENROLLMENT FORM

EMPLOYER NAME:

LAST NAME: **FIRST NAME:** **MI:**

STREET: **CITY:** **STATE:** **ZIP:**

PHONE #: - **EMAIL:**

SOCIAL SECURITY #: **DOB:** / /

Please list all dependents and spouse (if applicable) who will be covered under your plan. As a general rule, any family member you claim on your Federal taxes as a dependent is eligible for coverage. Please note if you already have FlexCards, they are valid for three years. You do not need to request new cards. New cards are sent automatically to replace existing cards 30 days prior to expiration. Each Family is allowed two free cards. Additional cards are $10.00 per card debited directly from your FSA.

RELATIONSHIP	LAST NAME	FIRST NAME	MI	SSN#	DOB	ISSUE CARD Y/N?
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CHILD						

BENEFIT ACCOUNTS	ENTER PER PAY	NUMBER OF PAYS	ANNUAL ELECTION
FSA – Medical			$0.00
DCA – Dependent Daycare			$0.00

(Dependent daycare maximum $5,000 annually or $2,500 for married individuals filing a separate return

I hereby apply for the options listed above. I authorize my employer to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in effect throughout the plan year, unless I have a change in family status. I also understand that any unspent money remaining in my account(s) at the end of the plan year will be forfeited.I agree that if my employer pays out to FlexSave, whether by inadvertence or design, more than I was entitled to receive, my employer may withhold amounts from my wages until the improperly paid portion has been recovered. My submission of this form authorizes my employer to reduce my compensation to recover amounts improperly paid from my FSA and/or DCA.

DATE: / / **SIGNATURE:**_____

After completing this form, please forward it to your HR Department