



First Benefit Administrators

FSA HEALTH CARE ENROLLMENT FORM

PLAN YEAR _____ THROUGH _____

EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

| | | | |
|----------------------------|---|-------|------------------------|
| LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NUMBER |
| _____ | _____ | _____ | _____ |
| DAYTIME PHONE () _____ | <input type="checkbox"/> CHECK BOX IF ADDRESS HAS CHANGED | | |
| ADDRESS _____ | CITY _____ | | |
| STATE _____ ZIP CODE _____ | E-MAIL _____ | | |

(Employer Complete) Employee Effective Date For Plan _____
MONTH/DAY/YEAR

HEALTH CARE SPENDING ACCOUNT YES, I ELECT TO PARTICIPATE

I AM PAID - WEEKLY _____ BI-WEEKLY _____ MONTHLY _____ SEMI-MONTHLY _____ AND ON

THAT BASIS CHOOSE TO REDIRECT A PRE-TAX DEDUCTION *PER PAY PERIOD* AS INDICATED ABOVE IN THE AMOUNT OF:

\$ _____

THE FIRST PAYROLL DEDUCTION DATE IS: _____

AS AN ELIGIBLE EMPLOYEE, I UNDERSTAND A COPY OF THE SUMMARY PLAN DESCRIPTION (SPD) IS AVAILABLE AT MY PLACE OF EMPLOYEMENT AND UNDERSTAND THE BENEFITS, RIGHTS AND OBLIGATIONS INCLUDED IN THIS PLAN. I UNDERSTAND THAT ELIGIBLE EXPENSES FOR ME, MY SPOUSE AND DEPENDENT, AS OUTLINED IN THE SPD AND IRS PUBLICATION 502, AND WHICH ARE NOT REIMBURSED UNDER ANY OTHER MEDICAL PLAN AVAILABLE TO ME, QUALIFY FOR REIMBURSEMENT UNDER THIS PLAN. I AGREE TO CONTACT THE PLAN ADMINISTRATOR/EMPLOYER FOR CLARIFICATION IF I HAVE ANY REASON TO BELIEVE THAT I HAVE RECEIVED A BENEFIT FOR ANY EXPENSES WHICH DO NOT QUALIFY. I UNDERSTAND THIS REDIRECTION MAY HAVE MINIMAL EFFECT ON MY SOCIAL SECURITY BENEFITS. I UNDERSTAND THAT AMOUNTS REDIRECTED INTO THIS ACCOUNT MAY NOT BE USED IN ANY OTHER BENEFIT PLAN, REFUNDED OR CARRIED OVER TO THE FOLLOWING YEAR. I UNDERSTAND THAT, EXCEPT FOR CERTAIN FAMILY SITUATIONS AS DEFINED BY THE SPD, MY PARTICIPATION IN THIS PLAN IS FOR THE ENTIRE PLAN YEAR. PRIOR TO THE BEGINNING OF EACH PLAN YEAR, I WILL BE GIVEN AN OPPORTUNITY TO CHANGE THE AMOUNT OF MY ELECTION OR REVOKE MY PARTICIPATION IF I DO NOT SUBMIT A NEW ELECTION, THE PRIOR YEAR'S ELECTION WILL REMAIN IN EFFECT FOR THE NEW PLAN YEAR. I UNDERSTAND THAT IN THE EVENT OF MY DEATH, ANY BENEFIT DUE ME WILL BE PAID TO MY ESTATE.

SIGNATURE

DATE

A COPY OF THIS COMPLETED FORM SHOULD BE RETAINED FOR YOUR FILES AND THE ORIGINAL RETURNED TO YOUR HUMAN RESOURCES OFFICE OR YOUR BENEFITS ADMINISTRATOR

THEN MAIL OR FAX THE COMPLETED SIGNED FORM TO: **FIRST BENEFIT ADMINISTRATORS, INC**
 13080 Belcher Road South, Suite A
 Phone: 727.530.4144 ♦ Fax: 727.535.3977
www.firstbenefitadmin.com