Medical Flexible Spending Cafeteria Plan

Enrollment Form

EMPLOYER INFORMATION

Company Name

EMPLOYEE INFORMATION

Employee Last Name	First Name	Social Security Number	
Street Address	City	State	Zip
Daytime Phone Number	Email		

MEDICAL FLEXIBLE SPENDING ACCOUNT PLAN ("FSA") ELECTION

- I elect to participate in the FSA as shown below. I agree to reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to the FSA I understand that this reduces my wages for Social Security purposes.

- I understand that this election must be made annually, in advance of the plan year, and that I may not change this election unless I experience a qualifying event as defined by IRS regulations. Examples of qualifying events include but are not limited to Marriage, Divorce, change in employment status, change in spouse employment status, dependent no longer eligible, birth or adoption of a child. Changes made due to qualified status changes must be made within 31 days of the qualifying event.
- Claims for reimbursement under the FSA must be for services received and paid during the plan year and must be submitted for reimbursement within three months of the end of the plan year or within three months of termination if my participation in the plan terminates prior to the end of the plan year.
- I understand that any contributions in the FSA not used for eligible expenses during my participation in the plan and during the plan year will be forfeited to the plan.

FSA Election – Minimum $100

Total Annual Contribution:

$

Must be a whole dollar amount

Election is for the Plan Year

FSA Plan general guidelines:

- Incurred for services or supplies by me or my eligible dependents,
- Incurred on or after the effective date of my spending account,
- Have not been reimbursed in any other way,
- Internal Revenue Service approved health care
- "Use It Or Lose It",
- You must file a claim with valid substantiation in order to receive reimbursement

General guidelines for what is a reimbursable expense may be found in IRS publication 502.

TERMS AND CONDITIONS

I understand that:

1. Only an IRS-approved qualifying life event (as described in the FSA Summary Plan Description) allows me to change or suspend my participation in the FSA.
2. I cannot include any insurance plan premiums in my above projected expenses because these are not reimbursed by the FSA.
3. I have 90 days after the Plan Year to file claims incurred this Plan Year (no exceptions).Any money in my account after that time will be forfeited.
4. The amount a Highly Compensated Employee may contribute to the FSA may be limited, subject to results of a nondiscrimination test.
5. All income tax issues should be discussed with my tax advisor.
6. I should retain a copy of this enrollment form for my files.
7. It is my responsibility to see that the correct deduction comes out of my paycheck within 30 days of my participation and to notify my employer immediately if this does not occur.
8. I have read the FSA Summary Plan Description (SPD) and agree to be bound by its provisions.

I have read and agree to the terms and conditions set forth on this Agreement.

Employee Signature	Date

Send completed form and documentation to TotalBen.

FAX: (718) 535-7071

Mail: TotalBen LLC
P.O. Box 100496
Brooklyn, NY 11210

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