FSA

Employee Enrollment Authorization Form

REQUIRED EMAIL ADDRESS: _____

Employer	Plan Effective Date	Payroll Deduction Start Date	
Employee's Last Name	First Name	Mid..Init.	Phone #
Employee's Address: (Reimbursement Checks are sent to this address) Street	City	State	Zip
Social Security Number ___ ___ ___ / ___ ___ / ___ ___ ___ ___	Date of Birth _____ /____ / ____	☐ Male ☐ Single ☐ Divorced ☐ Female ☐ Married _	Hire Date__ ____ ___ Hours Worked Weekly_____
Are you paid: ☐ Weekly (52/yr) ☐ Bi-weekly (26/yr) ☐ Semi-Monthly (24/yr) ☐ Monthly (12/yr) ☐ Other _____			

AUTHORIZATION FOR COVERAGE AND PARTICIPATION

I request the following amounts to be deducted from my salary as follows:

	$ Per Pay Period		#Pay Periods		Total $ for Plan Year
Health Care Spending Account	$_____. ____	X	_____	=	$ _____
Dependent Day Care Spending Account	$_____. ____	X	_____	=	$ _____
Insurance Premium Other Insurance	$_____. ____	X	_____	=	**$** _____

DIRECT DEPOSIT ELECTION AUTHORIZATION - OPTIONAL

**If left blank, we will default to check. **

I elect and direct Administrative Solutions, Inc. to initiate deposits and/or corrections to the financial institution listed below.

Direct Deposit Reimbursements are electronically deposited into your bank account. **A copy of your voided check must be attached.** Deposit slips are not accepted.

☐ Begin Deposits
☐ Continue Deposits
☐ Cancel Deposits

☐ Checking
☐ Savings

Routing #:_____
Account #:_____
Bank Name: _____

I understand electronic funds transfer (EFT) will be initiated on the normal check run date. Deposits may take up to three (3) business days to appear in the designated account. Returned items due to incorrect banking information will be assessed a $25.00 fee.

******PLEASE ATTACH COPY OF VOIDED CHECK******

I certify the information above to be correct and true to the best of my knowledge. I authorize payroll deductions from my earnings for any contribution I am making toward the cost of any of the above. Applicable account(s) at the end of the plan year not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Section 125 Flexible Benefit Plan deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status as defined in the Plan Document.

_____ _____
Signature Date

DECLINATION OF COVERAGE AND PARTICIPATION

I have been given the opportunity to participate in the above Section 125 Flexible Benefit Plan and have elected not to do so. If I later wish to enroll in this Plan, I understand that my eligibility and effective date will be determined according to Plan Document provisions elected by my Employer.

_____ _____
Signature Date

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