



Flexible Spending Account (FSA) Enrollment Form

Please complete and submit this worksheet to your employer. This is an internal document used by your employer for data collection purposes. Worksheets submitted to Discovery Benefits will not be processed.

* = Required Fields

Step 1: Participant Information

<input type="text"/> *Employer Name (Do not abbreviate)	<input type="text"/> *4-Digit Employee ID Number
<input type="text"/> *Participant Name (First, MI, Last)	<input type="text"/> - <input type="text"/> - <input type="text"/> *Social Security Number
<input type="text"/> *Participant Mailing Address	<input type="text"/> Email Address (If provided, all notifications will be sent via email)
<input type="text"/> *City	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> *State *Zip
<input type="text"/> - <input type="text"/> - <input type="text"/> Day Telephone	<input type="text"/> *Birth Date (mm/dd/yyyy)
<input type="text"/> *Hire Date (mm/dd/yyyy)	<input type="text"/> *Hire Date (mm/dd/yyyy)
<input type="text"/> Gender (Please circle one): Male / Female	<input type="text"/> Marital Status (Please circle one): Married / Single

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. *Please Note: Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Plan Type (if enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer)

*Annual Election (if employer funded, note 'ER' next to amount)

*Number of Pay Periods (if enrolling mid-year, please enter the number of remaining pay periods within the plan year)

*Per Pay Period Amount (to be deducted each pay period)

*Date of First Payroll (mm/dd/yyyy)

*Participant Effective Date (mm/dd/yyyy)

*Pay Frequency

Medical FSA

Limit set by employer

\$
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=
Bi-Weekly 26

Dependent Care Account

Limit set by employer up to IRS maximum

\$
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=

Limited FSA

Limit set by employer if this plan type is offered

\$
÷
=

No, I do not wish to participate in any Employer sponsored Flexible Spending Accounts.

Step 4: Authorization

I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

*Participant Signature
*Date