



# FSA Enrollment Form

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: **Monroe County Intermediate School District** \_\_\_\_\_

Participant Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Pay Period:

- Weekly  Semi-Monthly (twice a month)
- Bi-Weekly (every other week)  Monthly

**EMPLOYER USE**

Please complete for mid-year enrollments

Date of first deduction: \_\_\_\_\_ Eligibility date: \_\_\_\_\_

\_\_\_\_\_

## PREMIUM CONTRIBUTIONS

- I elect to participate (check all that apply)
- Health Insurance  Group Life Insurance  Disability Insurance  Dental Insurance
- HSA Contributions  Vision Insurance  Other(s) \_\_\_\_\_  
*The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.*
- I elect NOT to participate

## MEDICAL REIMBURSEMENT ACCOUNT

- I elect to participate \$ \_\_\_\_\_ annually (may not exceed employer limit of \$ \_\_\_\_\_)  
*Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments*
- This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (dental/vision only, if offered by your employer)
- I elect NOT to participate

## DEPENDENT CARE ACCOUNT

- I elect to participate \$ \_\_\_\_\_ annually  
*Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments*
- I elect NOT to participate

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year may be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_