ENROLLMENT FORM
FLEXIBLE SPENDING ACCOUNTS

(PLEASE PRINT CLEARLY)

Benefit Resource, Inc.
plans that perform

2320 Brighton-Henrietta Townline Rd
Rochester, NY 14623
Phone: (800) 473-9595
Website: www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: E-mail Address:

Hire Date: / / Birth Date: / / Gender: ☐ Male ☐ Female

Employee Status: ☐ Full-Time ☐ Part-Time

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with Section 125 of the Internal Revenue Code.

B. FLEXIBLE SPENDING ACCOUNTS *Please enter your FSA election(s).*

(Refer to your Plan Highlights for election maximums)	**Per Pay Deduction**	**Plan Year Election**
☐ Medical Flexible Spending Account	$	$
☐ Dependent Care Flexible Spending Account	$	$

C. EMPLOYEE CERTIFICATION

- I have received and read the printed material which explains my Plan and my options under it. I understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual, and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current Plan Year. Any choices above may be modified only as defined in the Plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that any unused amounts in either Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.
- I understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my Account(s). I also understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

Signature: _____ Date: _____ / _____ / _____

D. PAYROLL DEDUCTION INFORMATION *Employer must complete this section for employee to be enrolled.*

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other _____
- **Pay Date of first FSA deduction(s):** _____/_____/
- **Number of pay dates on which FSA deduction(s) will be taken during this Plan Year:** _____

Please return completed form to your employer.

The Employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.