FSA Enrollment Form

For more information, please visit our website or contact Customer Service.

www.benefitsworkshop.com/npb ● (888) 537-3539 ● info@benefitsworkshop.com

Name _____

Social Security Number _____ Is this a new address? ☐ **YES** ☐ **NO**

Address _____

City, State, ZIP _____

Phone _____ ☐ cell ☐ home ☐ work Email _____

Please choose one.

☐	☐	☐
Election during Open Enrollment	**Election during a Plan Year**	**Amendment to an existing election**
Effective Date **10/1/2022**	Effective Date _____	Effective Date _____

Please indicate your selection(s) below.

Health Care FSA	**Dependent Care FSA**
Annual Amount **$** _____	Annual Amount **$** _____
Number of Paydays _____	Number of Paydays _____
Contribution each Payday **$** _____	Contribution each Payday **$** _____
The maximum annual amount is $2,850 per plan year.	The maximum annual amount is $5,000 per plan year, or $2,500 if married & filing separately.

Order additonal cards (optional).

A BenefitsWorkshop Debit Card will be ordered in the employee's name only. A card can be ordered for your spouse or dependents for a $5.00 handling fee, which will be deducted from your account balance. By providing the requested information, you are authorizing BenefitsWorkshop to deduct this fee from your account. Individual cards are not required to access the account.

Name _____ SS# _____ ☐ spouse ☐ child

Name _____ SS# _____ ☐ spouse ☐ child

By signing this form, I authorize my employer to redirect (reduce) my taxable pay by the indicated amounts. I understand and agree that: **(1)** I have read the plan materials available to me and I understand the operation and rules of the plan. **(2)** I cannot change or cancel my election for the remainder of the plan year unless I have a qualifying event. **(3)** I cannot transfer money between the reimbursement accounts. **(4)** Unspent funds will be forfeited after the grace period ends. **(5)** The elections I have made are in accordance with the plan documents and the provisions of Internal Revenue Service Code Section 125, and will be taken out in equal installments throughout the year. **(6)** I will only use the Debit Card to pay for eligible medical expenses for myself or my covered dependents. **(7)** I will not use the debit card for any medical expense that has already been reimbursed, and I will not seek reimbursement under any other health plan for expenses paid for with the debit card. **(8)** I will acquire and retain sufficient documentation for any expense paid with the debit card. **(9)** I understand that failure to submit documentation for debit card transactions (when required) in a timely manner may result in my debit card being block until the requested documentation is submitted. I also understand that repayment of ineligible or undocumented transactions may be required.

Participant Signature _____ Date _____