FSA/HSA ENROLLMENT FORM

EMPLOYEE INFORMATION

Employer Name:			
Employee Hire Date:	Department:		
☐ **Male** ☐ **Female** ☐ **X**	Employee Email Address:		
Last Name:	First Name:		M.I.:
Soc. Sec.:	Home Address:		
City:		State:	Zip:
Marital Status: ☐ **Married** ☐ **Single**	Birth Date:	Contact Phone:	

HR to Complete	
Effective Date:	
☐ **Key Employee** ☐ **Highly Compensated**	Salary: *(only if one of these is checked)*
☐ **Hourly EE** ☐ **Salaried EE**	Number of FSA/DCAP/HSA Pay Periods Per Year: ☐ **26** ☐ **24** ☐ **Other**
First Pay Date of the New Plan Year:	

For Plan Year:

If covering Spouse, please enter Date of Marriage:

Benefit Election Options	Election	Salary Reduction Amount	Benefits Office Use Only
OPTION I: Premium Payment Component Group insurance premiums you pay through payroll deduction	**Automatic**	Amount necessary to pay for your share of all group insurance premiums	$ *Annual Election*
OPTION II: General Purpose FSA Component Covers all eligible 213(d) services	☐ **Yes** ☐ **No**	$ *per pay period*	$ *Annual Election*
OPTION III: Limited Purpose FSA Component Covers Only Dental/Vision 213(d) services (may be combined with HSA)	☐ **Yes** ☐ **No**	$ *per pay period*	$ *Annual Election*
Option IV: Dependent Care Component (available to all eligible employees)	☐ **Yes** ☐ **No**	$ *per pay period*	$ *Annual Election*
Option V: HSA Component Covers all eligible 213(d) services (only available to employees enrolled in the HDHP who are eligible to participate in an HSA)	☐ **Yes** ☐ **No**	$ *per pay period*	$ *Annual Election*

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Elections Irrevocable Unless Exception Applies

I understand that I cannot change or revoke this Agreement as of any date prior to the next Plan Year, unless a Change in Status Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Status Event, as described in the Plan.

Additional Terms

- I agree that my Compensation will be reduced by the amount of my required contribution for the Benefits that I have elected under the Plan and that such Salary Reductions will continue for each pay period until this Agreement is amended or terminated. I understand that my contribution for the health insurance benefits may be automatically increased or decreased for changes by the Plan Administrator. I also understand the following:
- Signing this Agreement does not initiate my coverage under the health insurance policies. I must complete a separate health insurance enrollment form to start my health insurance coverage.
- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- Any unused amounts that may remain in my Health FSA and/or DCAP Accounts after reimbursing my eligible expenses incurred during the Plan Year may be forfeited, unless otherwise allowed by the Plan.
- Prior to the start of each of each year I will be offered the opportunity again to elect Premium Payment, Health FSA and/or DCAP coverage for the following Plan Year. If I do not complete and return a new Agreement at that time, then I will be treated as having elected to waive all pre-tax benefits under the Health FSA, DCAP and HSA Components of the Cafeteria Plan and my pre-tax coverage will cease at the end of the Plan Year.

Waiver of Pre-Tax Benefits Under the Salary Reduction Plan; Election of After-Tax Benefits

(Check box if applicable; do not check this box if you have checked one or more boxes in the section above)

☐ *I elect to waive all pre-tax benefits under the Plan. I understand that if I have enrolled for health insurance coverage on a separate benefit enrollment form, I will pay my share of the contribution with after-tax payroll deductions. Except for a Change in Election Event for the applicable Benefit(s) (as described below), I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverage(s) shall be outside the Plan.*

I have read and agree to the terms of participation and to any applicable certifications set forth in this Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.

Employee's Signature: ______________________________ Date: ____________________

Plan Administrator's Signature: ______________________________ Date: ____________________

Administered by: TPSC Benefits

P.O. Box 1894 // Tacoma, WA 98401-1894 // 253.564.5611, ext. 210 // 1.800.426.9786, ext. 210

tpscbenefits.com