FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Please complete, sign and date the completed form and submit to your HR Department.

Please select one: ☐ **Open Enrollment** ☐ **New Hire** ☐ **Change of Status**

Employer Name: Carnegie Institution of Washington	**Plan Year: 1/1/2018 – 12/31/2018**

Employee Name:

Social Security Number:	**Date of Birth:**	**Date of Hire:**

Please select one: ☐ New Address ☐ No Changes (Applicable if previously enrolled with The 125Company, Inc.)

Address:

City:	**State:**	**Zip:**

Email: ***Email address required for all system notifications**	**Day Phone#:**

I request my section 125 reimbursements to be direct deposited into the following account. I understand this arrangement will stay in place until I submit a change. **Please include a voided check with your submission.**

Bank Name:	**Type of Account:** ☐ **Checking** ☐ **Savings**
Bank Routing #:	**Account#:**

I authorize my Section 125 Health FSA and/or Dependent FSA, HRA and/or Transportation (as applies) reimbursement to be sent to the financial institution named above to be deposited in the designated account. In the event funds are deposited erroneously into my account, I authorize my Section 125 provider to debit my account for an amount not to exceed the original amount of credit. I understand that all direct deposits are made through the Automated Clearing House (ACH) and that Funds availability is subject to the terms and limitations of the ACH as well as my financial institution

Enrollment Information: Please note FSA Funds will be automatically rolled whether you elect, or not for the new plan year.

Healthcare Spending Account (FSA) - Annual Maximum: $2,650.00 Minimum: $100.00

Effective Date:	**Per Pay Period Amount: ____**
Annual Election Amount:	**Payroll Effective Date: ____**

Limited Healthcare Spending Account (LPFSA) - Annual Maximum: $2,650.00 Minimum: $100.00

If you are enrolled in an HSA account you can only elect a Limited FSA. Please see plan rules for eligible expenses.

Effective Date:	**Per Pay Period Amount: ____.**
Annual Election Amount:	**Payroll Effective Date: ____**

☐ **I choose to waive coverage for a Healthcare Spending Account FSA or LPFSA**

Dependent Care Spending Account (DCAP)

Annual Maximum: $5,000.00 per IRS regulations. Minimum: $100.00

The maximum exclusion under a DCAP for married individuals filing a joint return (or for a single parent) is $5,000. Married individuals filing separately are subject to a lower exclusion ($2,500). Other IRS rules or SPD may apply.

Effective Date:	**Per Pay Period Amount: ____**
Annual Election Amount:	**Payroll Effective Date: ____**

☐ **I choose to waive coverage for a Dependent Care Spending Account (DCAP)**

I authorize my employer to reduce my salary in an amount necessary to make the contributions that I have specified on this form. I understand that my coverage begins on my effective date in the plan and terminates at the end of the plan year, or on my termination date (whichever comes first). If I have requested additional card(s) for my dependent (s), my signature below authorizes the use of the card. Any unused balance in my FSA, DCAP account(s) will be forfeited if I do not request reimbursement for eligible expenses within my plan's grace period/run-out period as specified by our plan design or within the specified number of days after my termination date as outlined in our plan design.

Employee Signature:	**Date:**