



Redwood Health Services

Return this form to your employer, not to RHS.

Debit Card Enrollment Form and Agreement

Employer _____ Employer Tax ID # _____ FSA Plan Year _____

Employee Last Name _____ First _____ MI _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____ New Address? Y N

Employee SS# _____ Phone _____ Marital Status _____ Gender M F

Date of Hire _____ Eligibility Date if New Hire/Rehire _____ E-mail _____

EMPLOYER FSA FUNDING
Annual Medical FSA benefit per employee \$ _____ per employee/spouse/children/family \$ _____

EMPLOYEE FSA FUNDING
Payrolls in Plan Year _____ Date of first contribution ____/____/____ Weekly Bi-Weekly Semi-Monthly Monthly
Medical FSA Plan
\$ _____ Maximum employer allowed
\$ _____ Annual election
 I elect to waive coverage
Dependent Care FSA (Non Medical)
\$ _____ Maximum employer allowed
= \$ _____ Annual election (\$5,000 max if married filing jointly) (\$2,500 max if married filing separately)
 I elect to waive coverage

List FSA or HRA dependents below:

Table with 8 columns: Social Security #, Last Name, First Name, MI, Relationship, Date of Birth, Gender, Extra Card. Contains 4 rows for dependents.

FSA Plan Agreement I understand and agree that:

I may elect coverage under any or all of the above components. I cannot change or revoke this FSA agreement during the plan year, unless the plan administrator determines that I will have incurred a qualifying change in status under IRS Code Section 125.

Debit Card Holder Agreement I understand and agree that:

My employer and/or I have the right to suspend or terminate my card. Any violation of my cardholder agreement will result in suspension or termination of my card. Fraudulent use of my card under the limitations set forth by my employer and the IRS Code Section 125 regulations includes but is not limited to: purchase of non-eligible products or services; purchases for ineligible individuals; providing card access to inappropriate individuals; false claim submission to document transactions; failure to make the necessary fund replacement in my Reimbursement Account.

I certify that I have read, understand and agree to the terms above. Number of extra cards @ \$5.00 per card: _____ Additional debit card monthly fee \$2.50

Employee's signature: _____ Date: _____