Redwood Health Services

Employee/Employer FSA Enrollment Form

Return this from to your employer, not to RHS

EMPLOYER

Name _____ Employer Tax ID # _____ FSA Plan Year _____

Payrolls in Plan Year_____ Date of first contribution _____/_____/_____ ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

EMPLOYER ONLY FSA FUNDING (Amount employer will contribute to the FSA - not to exceed IRS maximum.)

Annual Medical FSA benefit $_____ per employee/spouse/children/family.

EMPLOYER FSA MAXIMUM (Maximum amount employer will allow - not to exceed IRS maximum of $3,300.)

Medical FSA Plan $_____ Maximum employer allowed | **Dependent Care FSA (Non Medical)** $_____ Maximum employer allowed

EMPLOYER TRANSPORTATION MAXIMUM – 132(f) Plan (Maximum amount employer will allow - not to exceed IRS maximum of $325.)

Transit $_____ Maximum employer allowed | **Parking** $_____ Maximum employer allowed

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 _____

EMPLOYEE FSA FUNDING (Amount employee elects to contribute - up to employer maximum.)

Medical FSA Plan

$_____ Annual election

☐ I elect to waive coverage

Dependent Care FSA (Non Medical)

$_____ Annual election ($5,000 max if married filing jointly) ($2,500 max if married filing separately)

☐ I elect to waive coverage

EMPLOYEE FUNDING TRANSPORTATION – 132(f) Plan (Amount employee elects to contribute - up to employer maximum.)

Transit

$_____ Annual election ☐ I elect to waive coverage

Parking

$_____ Annual election ☐ I elect to waive coverage

List FSA or HRA dependents below: (If additional space is needed, please use another sheet.)

Social Security #	Last Name	First Name	MI	Relationship	Date of Birth	Gender	Extra Card
						☐ M ☐ F	☐
						☐ M ☐ F	☐
						☐ M ☐ F	☐
						☐ M ☐ F	☐

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. Any funding provided by me will be withheld from my paycheck on a pre-tax basis. Participation in this plan reduces my Social Security withholdings and could reduce my Social Security benefits. Completion of this form does not guarantee insurance coverage will be initiated. In most cases, an application for insurance must also be completed. Reimbursement will be available only for eligible expenses under IRS Code Section 125. Any unused contributions at the end of the plan year shall be retained by the plan to offset administrative expenses and costs.

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. These terms also apply to any extra cards that I may order. I must retain all my RHS Debit Card receipts for my records in the event the IRS and/or RHS need to audit my account for Code Section 125 compliance.

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: _____