



A UnitedHealthcare Company

# Flexible Spending Account (FSA) Enrollment Form

## Applicant information

UMR ID/ Social Security number \_\_\_\_\_ PEBP employee ID# \_\_\_\_\_ Pay center \_\_\_\_\_

First name \_\_\_\_\_ MI \_\_\_\_\_ Last name \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Gender \_\_\_\_\_ Marital status \_\_\_\_\_ Date of birth     /     /      
MM DD YYYY

Email \_\_\_\_\_ Phone number \_\_\_\_\_

Date of hire     /     /      
MM DD YYYY

Plan effective date     /     /      
MM DD YYYY

Payroll schedule      Monthly      Semi-monthly      Bi-weekly      Weekly

New enrollment/change \_\_\_\_\_ If change, why \_\_\_\_\_

## Health care (For participants on EPO, LDPPO or CDHP with HRA)

Contribution	# of pay periods	Annual election
\$ _____	X _____	= _____

Cannot exceed IRS maximum \$3,400

Note: Central payroll withholds monthly. The annual election must equal the per payroll deduction multiplied by the number of pay periods remaining for the fiscal year.

Note: Minimum \$100 per year, maximum \$3,400 per year.

## Limited purpose flexible spending account (For participants on the CDHP with HSA)

Limited purpose spending account (for participants on the CDHP with HSA)  
For use in conjunction with the HSA. May only be used for vision and dental expenses.

Contribution	# of pay periods	Annual election
\$ _____	X _____	= _____

Note: Central payroll withholds monthly. The annual election must equal the per payroll deduction multiplied by the number of pay periods remaining for the fiscal year

Note: Minimum \$100 per year, maximum \$3,400 per year, for use in conjunction with the HSA. May only be used for vision and dental expenses.

(Continued)

## Dependent care (For eligible children under age 13 or eligible dependent who is incapable of self care)

My taxable compensation is to be reduced for qualifying dependent care expenses (example: daycare, day camp, before/after school care) in the amount of:

Contributions	# of pay periods	Annual election
\$ _____	X _____	= _____
		Cannot exceed \$7,500 per household

Note: Central Payroll withholds monthly. The annual election must equal the per payroll deduction multiplied by the number of pay periods remaining for the fiscal year.

Note: Minimum \$100 per year, maximum \$7,500 per year for married couples filing a joint tax return, or single individual. \$3,750 if married and filing a separate tax return.

## Authorization

**Please select your enrollment option below, then sign and date your form and submit to your benefit services department.**

I elect to participate in my employer's FSA plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the plan year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire plan year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the current plan year may be forfeited depending on the terms of my employer's plan.

If the plan administrator determines that an expense I submitted for reimbursement was not a qualified expense under the plan documents, I will immediately reimburse the plan for the entire amount of the unqualified expense. If I fail to timely reimburse the plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the plan in order to reimburse the unqualified expense.

I decline enrollment in my employer's FSA plan.

Employee signature \_\_\_\_\_ Date     /     /      
MM DD YYYY

You will pay a small administration fee of \$3.15 per month to participate in one or both (HCFA and/or DCFA) flexible spending accounts.

Please submit completed form (choose 1):

**Email**  
**umr-fsa@umr.com**

**Mail**  
**UMR**  
**P.O. Box 8022**  
**Wausau, WI 54402-8022**

**Fax**  
**866-751-2440**

