Flexible Spending Account Enrollment Form

Please check one of the following:

☐ Open Enrollment for New Fiscal Plan Year:

☐ New Employee: _____

☐ Change of Contribution/Payroll Deduction:

Event / Reason for Change: _____

Date of first paycheck affected:_____

(Indicate New Annual Election and per Pay Period Contribution Amount in Section 2)

TRISTAR Benefit Administrators
PO Box 65887 - West Des Moines, IA 50265

Shaded Area Completed by Employer

Group Number	Location	Employee Classification	Effective Date

1. Employee Information

Last Name / First Name / Middle Initial	Date of Birth (mm/dd/yyyy)	Gender: Male ☐ Female ☐
Home Mailing Address	Social Security Number	Home Telephone No.
City / State / Zip	Marital Status	Date Employed (mm/dd/yyyy)
Enrollee's Employer's Name	Email Address for Correspondence	
Spouse's Name	Date of Birth (mm/dd/yyyy)	Gender: Male ☐ Female ☐
Child's Name	Date of Birth (mm/dd/yyyy)	Gender: Male ☐ Female ☐
Child's Name	Date of Birth (mm/dd/yyyy)	Gender: Male ☐ Female ☐
Child's Name	Date of Birth (mm/dd/yyyy)	Gender: Male ☐ Female ☐
Child's Name	Date of Birth (mm/dd/yyyy)	Gender: Male ☐ Female ☐

2. Medical Reimbursement Plan

MEDICAL REIMBURSEMENT PLAN — CHOOSE ONE BELOW

☐ **General-Purpose Health FSA** ☐ **Limited Health FSA (Vision / Dental / Preventive Care)**

Your Election Amount $ _____ ÷ _____ = $ _____

Total Annual Before-Tax Dollars / Number of Pay Periods / Contribution / Pay Period

☐ I do not elect to participate in the Medical Reimbursement account

☐ This is a change. New annual election $_____ New per paycheck contribution $_____

3. Dependent Care Reimbursement Plan

DEPENDENT CARE REIMBURSEMENT PLAN

Maximum Allowable amount if Single, Head Of Household or Married, Filing Joint Return: $5,000 per Plan Year

Maximum Allowable amount if Married, Filing Separate Return: $2,500 per Plan Year

Your Election Amount $ _____ ÷ _____ = $ _____

Total Annual Before-Tax Dollars / Number of Pay Periods / Contribution / Pay Period

☐ I do not elect to participate in the Dependent Care Reimbursement account

☐ This is a change. New annual election $_____ New per pay period contribution $ _____

4. Designate Your Beneficiary

I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible benefits spending account should be made payable to the undersigned.

Beneficiary:_____ Relationship:_____

5. Premium Payment Plan Election

☐ Yes, I authorize my employer to reduce my salary before taxes by the employee contribution amount, as designated by my employer, to cover the premium for my employer-sponsored health insurance plans in which I have elected to enroll.

☐ No, I am declining coverage.

6. Read and Sign

My signature on this form certifies that I have received and read the printed material explaining my employer's flexible benefits program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (e.g., marriage, divorce, birth, or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.

Employee Signature _____ **Date** _____