Complete this form and return it to your benefits representative

Employee Information

Employer Name _____

Employee Name _____ Account Number or SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ ZIP Code _____

Date of Birth _____ Date of Hire _____ Gender ☐ Male ☐ Female

Add your email address to receive messages about your account: _____

Elections (Additional plan information can be found at www.conexis.com/myfsa)

Health Flexible Spending Account

NOTE: Health FSA employee salary reductions are limited to $2,500 for plan years beginning on or after January 1, 2013.

☐ I elect to participate $_____ per pay period x _____ remaining pay periods = $_____ Plan Year Total

☐ I elect to waive coverage

Dependent Care Flexible Spending Account*

Annual maximum allowable is:

- $5,000 if married filing jointly or single
- $2,500 if married filing separately

☐ I elect to participate $_____ per pay period x _____ remaining pay periods = $_____ Plan Year Total

☐ I elect to waive coverage

Employee Certification

- I understand I may elect coverage under any or all of the above components;
- I understand completion of this form does not guarantee medical insurance coverage will be initiated and, if applicable, an application for medical insurance must also be completed;
- I understand the terms of eligibility of this plan do not override the terms of eligibility of each of the available benefit plan options;
- I understand my election is irrevocable for the plan year unless I have a change in status or other qualifying event as defined in the Plan and IRS regulations, and the requested change is on account of and consistent with the event;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand participation in this plan reduces my social security withholdings and could reduce my social security benefits;
- I certify I have read and agree to the terms above.

_____ _____

Employee Signature Date

For Employer Use Only					
Company Name	Division	Effective Date	Pay Cycle	Entered in Payroll	Initial

*It is important to note the general annual maximum is set at $5,000.00, your maximum annual contribution amount may not exceed the earned income limitation. If you are single, the earned income limitation is your salary (excluding your contributions to the dependent care FSA plan). If you are married, the earned income limitation is the lesser of your salary (excluding your contributions to the dependent care FSA plan) or your spouse's salary.