Flexible Spending Account (FSA) Enrollment Form

To elect to participate in your employer's YourWay FSA benefit, please complete this enrollment form and provide it to your employer's HR contact.

1 EmployerInformation — Employer Use Only

Employer Name:	Employer Number:
Withholding Schedule: ◯ Weekly ◯ Bi-Weekly ◯ Semi-Monthly ◯ Monthly	
Effective Date:	First Withholding Date:
Enrollment Type: ◯ Open Enrollment ◯ New Hire ◯ Re-Enrollment	
Authorized Employer Signature:	

2 Participant Information

Social Security Number:	Date of Birth:	
First Name:	Middle Initial:	Last Name:
Address 1:	Address 2:	
City:	State:	Zip Code:
Phone:		
Email:	◯ Check if you want to receive Plan communications via email.	

FSA Benefit Elections (Please enter your FSA Elections below)

◯ Health Flexible Spending Account (FSA)	◯ Dependent Care Assistance Plan (DCAP)
Annual Election Amount: **(Not to exceed IRS or Plan maximum)** IRS Max: $3200.00	Annual Election Amount: **(Not to exceed IRS or Plan maximum)**IRS Max: $5000.00, or $2500 if married and filing seperately

- Elections must be made in advance of the start of the plan year and cannot exceed the IRS or Plan maximum contribution amount.
- Election amounts will be deducted pretax.
- Health FSA funds are available on the first day of the plan year for expenses incurred in the current plan year.
- Dependent C are funds are available as the funds are withheld from your payroll.
- All unused funds remaining at the end of the Plan's Runout or Grace Period (as applicable) will be forfeited back to your employer.

Authorization (Please acknowledge the below and sign)

- I understand that all elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in st atus. Please consult the plan document or summary plan description for a list of qualifying events.
- I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse and dependents. I also understand that daycare reimbursements will be available only for qualifying daycare expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.
- I understand that I must submit a claim and appropriate document ation (e.g., explanation of benefits, itemiz ed bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbur sed. I certify that I will only submit claims for r eimbursement under the Fle xible Spending Account Plan. I cer tify that I will not submit claims for r eimbursement under the Fle xible Spending Account Plan f or amounts that have already been reimbursed by another source nor will I seek reimbur sement for such amounts fr om any other source.

Participant Signature: ______________________ Date: ____________