DELTA HEALTH SYSTEMS

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Enrollment Form

FLEXIBLE SPENDING ACCOUNT

Employee Information

Your name (last, first, middle initial)			Social Security Number	
Address	**Street**	**City**	**State**	**Zip Code**

Date of Birth	Gender ☐ Male ☐ Female	Phone Number	E-mail Address

Company Name

☐ **I want to participate in our Flexible Spending Account (FSA).**

Reduce my future compensation by the total annual election shown below. This amount will be contributed to our FSA on my behalf. I understand this reduces my wages for social security purposes and may reduce my social security disability and retirement benefits. I understand I will not earn interest on my contribution. I understand that once I have made this election, I can only change it during the current election period if there is a qualifying "change in status" as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation will be forfeited and any funds in excess of $500 remaining at the end of any plan year (including the incurred claims Grace Period, if applicable), will be forfeited. Because Section 125(b) of the Internal Revenue Code establishes limits on participation in FSA by highly compensated employees and key employees which cannot be determined until the participation of all employees in both contributions and benefits has been tested under the applicable rules, it may be required by law that a portion of your salary reduction contributions to this FSA be returned to you regardless of the terms of your election to participate. Any amount so returned will become part of your taxable income.

NOTE: Changes in election allowed due to a qualifying "change in status" must be made no later than 30 days after the date of the qualifying change in status.

Pay Period: (Check the box which indicates the frequency of your paychecks)

☐ Weekly ☒ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ other_____

Health Care Annual Election*	**Dependent Care Annual Election***
$_____$2,650	**$**_____ $5,000 maximum if filing jointly or $2,500 maximum if filing separately

*The annual election should be based on the number of pay periods remaining.

Note: Dependent Care spending accounts are not medical spending accounts for a participant's spouse or children. This election is for day care (baby-sitting) of children or elderly dependents.

☐ I want to participate in the "Benny Card" prepaid FSA debit card program. Selecting this option disallows participation in "auto-rollover" reimbursements from my medical plan.

☐ I elect "auto-rollover" for FSA reimbursements from my medical plan to my FSA plan. By checking this box, I understand that unpaid amounts from my medical plan will automatically be reimbursed from my available Health Care FSA balance. Additionally, selecting this options disallows participation in the "Benny Card" prepaid FSA debit card program.

I hereby authorize my election(s) and pre-tax salary contribution(s) for the account(s) designated above for the plan year. I understand that this election is an annual election and cannot be changed during the plan year except in the case of a qualifying change in status. I understand that **any** unused balances for the Dependent Care FSA account and unused balances in excess of $500 for the Medical FSA account at the end of the plan year (including the incurred claims Grace Period, if applicable) shall be forfeited.

Employee Signature: _____ **Date:** _____

Employer Use Only

1. **FSA Election Effective Date** _____/_____/_____ **& Date of first FSA salary deferral deduction** _____/_____/_____
2. **Per pay period amount (annual election divided by the number of remaining pay periods) $**_____
3. **Employee Payroll frequency (please select one) □ Monthly □ Bi-weekly □ Semi-monthly □ Weekly**
4. **Number of FSA salary deferral deductions** _____