Flexible Spending Account Application (FSA)

HUMAN CAPITAL
A Vensure Employer Services Company

EMPLOYEE INFORMATION (please complete for all enrollments/changes)		
Subscriber Name (Last):	(First):	(M.I.):
Social Security:	Birthdate:	Phone:
Address:		
City:	State:	Zip Code:

BENEFIT SELECTIONS

(Please answer all sections salary redirection agreement)

1. PREMIUM CONTRIBUTIONS

On the appropriate benefit enrollment form(s), I have enrolled for elective insurance coverages. In lieu of premium accounts, I understand that my employer will make any necessary adjustments to my deduction should the premiums increase or decrease.

Health Insurance   Dental Insurance   STD Disablity   Life Insurance   Vision

2. HEALTH REIMBURSEMENT ACCOUNT (FSA).

I elect to participate in the health reimbursement account. To contribute into the medical FSA account, the yearly minimum is $25.00 and the maximum is $2,750.

Annual Contribution: ________________

3. DEPENDENT CARE REIMBURSEMENT ACCOUNT (FSA).

I elect to participate in the dependent care reimbursement account. To contribute into the dependent care FSA account, the yearly minimum is $25.00 and the maximum is $5,000.

Annual Contribution: ________________

4. ADOPTION ASSISTANCE REIMBURSEMENT ACCOUNT (FSA).

I elect to partipate in the adoption assistance reimbursement account. To contribute into the adoption assistance FSA account, the yearly minimum is $25.00 and the maximum is $10,160 for each eligible child.

Annual Contribution: ________________

BENEFICIARY DESIGNATION INFORMATION: (Please fill in for the beneficiary)

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the plan. I hereby designate as my beneficiary under the plan:

Beneficiary		
Name (Last):	(First):	(M.I.):
Social Security:	Birthdate:	Relationship:

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I have read and understand the explanation I have received regarding my options under the Human Capital Flexible Benefit Plan. I understand that I have the right to have Human Capital redirect my salary during the plan year and apply this amount toward the purchase of benefits I have designated above. I understand that my share of the cost of this coverage may change from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there in a change in my family status. I hereby apply for the options listed above, if necessary, I authorize Human Capital to adjust my pay(s) as required by my elections. I understand that the benefit options I have will remain in effect from 1/1/2020 – 12/31/2020, unless there is a family status change.

Calendar Year Lock-in: Once you have enrolled in the FSA accounts(s), you cannot stop participating or change the amount you are contributing until the next enrollment period. An exception may be made ONLY if you have a qualified change in family status event.

EMPLOYEE SIGNATURE DATE (MM/DD/YYYY)

ELECTION NOT TO PARTICIPATE: I UNDERSTAND THAT I AM DECLINING TO PARTICIPATE FOR THE FULL PLAN YEAR AND WILL NOT BE OFFERED ENROLLMENT AGAIN UNLESS I EXPERIENCE A FAMILY CHANGE.

EMPLOYEE SIGNATURE DATE (MM/DD/YYYY)

For Internal Use Only			
Date of Hire:	Effective Date:	Entry Date:	First Deduction Date:

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