Enrollment Form Paychex Benefit Account Flexible Spending Account

Client BIS ID	
Chent DIS ID	

Company Name Employee Name Address City	Employee Telephone Number () Social Security Number
Address City	Social Security Number
	Occide Occidently Individual
	State ZIP Code
Email Address	
SECTION 2 - ENROLLMENT OPTIONS (select one)	
New Enrollment or Annual Enrollment Changes Date of Hire / / /	□ Dependent care cost provider changes □ Dependent satisfies or ceases to satisfy dependent eligibility
Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met.	requirements Birth/Death of spouse or dependent, adoption or placement for adoption
Annual enrollment changes will be effective on the first payroll following January 1.	 Spouse's employment commenced/terminated Status change from full-time to part-time or vice versa by employee or spouse*
	☐ Eligibility or Ineligibility of Medicare/Medicaid
Date of Event / /	□ Change from salaried to hourly or vice versa* □ Marriage/Divorce/Legal Separation
Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to the Employer	☐ Unpaid leave of absence by employee or spouse ☐ Return from unpaid leave of absence by employee or spouse
within 30 days of the event.	* These changes are allowable only if eligibility is affected.
□ Annual Medical/Dental/Vision Election \$(Medical FSA) □ Discontinue my Enrollment in Medical/Dental/Vision Care □ To discontinue enrollment, a change in status reason must be selected. Notes: If you are enrolled only in DCA, a debit card will not be issued. Deper your dependent. To update this information please visit https://benefits Paychex Benefit Account page .	
SECTION 4 - AUTHORIZATION	
I hereby elect to participate in the Flexible Spending Account for the Plan Year agreement relating to the same benefits is hereby revoked. I cannot change or revoke change in status (also referred to as a qualifying event). If, during my next enrollment enrollment period, I will be treated as having elected to continue my employee election understand that all guidelines regarding enrollment are set forth in the Summary Plan	e this election at any date prior to the next plan year unless I experience a period, I do not complete and return a new election form during my n as set forth in this election form for the next plan year. As a participant, I
Reduction of Pay I understand that my pay will be reduced each pay period by the amount of my required contribution for the benefit option(s) I have elected until this agreement is amended or terminated. The reduction in my pay under this agreement will be in addition to any reductions under other agreements or benefit plans.	I agree to notify my Employer if I believe that any expense for which I have received reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer for any liability Employer may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
I understand that my pay reduction will be automatically adjusted if my required contributions change while this agreement is in effect and that the plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.	I understand that I will have a closeout period after the end of the plan year during which I can submit eligible expenses incurred during the plan year (and grace period if applicable). I understand that I will forfeit any remaining balances, including those in excess of any allowable carryover amount; I have at the end of the closeout period for which I
	have no eligible expenses to submit. SA with an HSA If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.
Employee Signature	///