Flexible Spending Account Enrollment Form

(Please complete this form and return it to your Employee Benefits Department)

NATIONAL BENEFIT SERVICES, LLC

Customer Care • Knowledge and Expertise • Organizational Excellence

Personal Information

Company Name	Employee Phone Number
Employee Name (First Name, Last Name)	Social Security Number (Required)
Street Address, City, State Zip	Date of Birth (Required)
Email Address (Required for ACH claim payment notification)	Date of Hire (Required)

Benefit Election

☐ Initial Request ☐ New Year Request ☐ Waive Participation

If you are part of a company health insurance plan your insurance premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction:

Number of pay periods per year: _____

☐ Health Care Expenses: $_____._____ Annual Election and
Please refer to the SPD for the maximum annual allowable election $_____._____ Per Pay Period Election

☐ Dependent Care Expenses: $_____._____ Annual Election and
Maximum annual allowable election is $5,000 OR $2,500 if married and filing taxes separately $_____._____ Per Pay Period Election

Debit Card (Health Care Expenses only)

☐ I have a debit card – please renew ☐ I do not have a card – please issue

☐ I had a card – please re-issue a new one ☐ Waive card option

You will receive 2 debit cards in the participant's name, one for you and one for your spouse or dependent
There may be a fee associated with the use of the debit card. Please contact your Employee Benefits Department for further information.

Employee Signature

I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) for eligible expenses under the plan, and understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).

Employee Signature	Date

Direct Deposit Request

Your Financial Institution		
Financial Institution Address		
☐ Checking Account ☐ Savings Account	Account Number	Routing Number

IMPORTANT! Please attach a voided check with this form (not a deposit slip).
Only for a savings account is a deposit slip acceptable

I (We) authorize National Benefit Services, LLC to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.

Employee Signature	Date

Welfare-508Custom
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