# Enrollment Form – Flexible Spending Accounts

**July 1, 2017 – June 30, 2018 Plan Year**

**GENERAL INFORMATION:**

Employee Name: _____ Social Security Number:_____

Date of Birth: _____ Date of Hire:_____ Email Address: _____

Mailing Address: _____ City:_____ State:____ Zip Code:_____

**FLEXIBLE SPENDING ACCOUNTS:**

☐ I hereby elect to participate in the Flexible Spending Accounts

☐ I hereby elect NOT to participate in the Flexible Spending Accounts

Note: After enrollment, WageWorks will mail a welcome guide to your home address. This guide provides you with important information about the different service options that are available to you (including direct deposit reimbursements and debit cards). Be sure to register online with WageWorks at www.wageworks.com after you receive your welcome guide.

| | Per Pay Period | # Pay Periods * | Annual Election |
|---|---|---|---|
| **Health Care FSA** | $ _____ | x _____ = | $ _____ |

(Annual Limit is $2,000)

☐ Full-Use FSA - For employees not covered under the Vi High Deductible Health Plan with HSA

☐ Limited Purpose FSA - For employees covered under the Vi High Deductible Health Plan (eligible FSA expenses are limited to Dental and Vision expenses not covered by health insurance).

| | | | |
|---|---|---|---|
| **Dependent Care FSA** | $ _____ | x _____ = | $ _____ |

(Annual Limit is $5,000 total combined with spouse)

Effective date of coverage:_____ The first payroll deduction will be on_____ , 20____

* Deductions are taken from the first two pay periods of each month.

**AUTHORIZATION & ACKNOWLEDGEMENT:**

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I enroll in the Vi High Deductible Health Plan with HSA, then I will be enrolled in the Limited Purpose FSA.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

_____ _____

Employee Signature Date