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CONCORDIA PLANS

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

## Employer/Employee Information

**Employer Name:**______________________ **CPS ER#:**____________________ **Plan Year:** __________________

**City:**____________________________________________________________ **State**_____ **Zip** ______________

**Employee Social Security Number:**__________________________

**Employee Name:**______________________________________________________________________________
(Last) (First) (MI)

**Home Address:**_______________________________________________________________________________

________________________________________________________________________________________________
(City) (State) (Zip)

**Daytime Phone Number:** _____________________ **Date of Birth:**___________________

**Effective Date:**___________________________ **(To Be Provided by Group Contact)**

## Employee Elections

**Medical Flexible Spending Account**

Plan Year Maximum of $2,650.00

☐ I want to contribute a total of $__________ during this Plan Year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

Are you or your spouse actively contributing to a Health Savings Account?

☐ No

☐ Yes: Your medical FSA must be limited to the reimbursement of dental and vision expenses until your health plan deductible has been met. Contact Further to remove the limit when your deductible is met.

**Dependent Care Flexible Spending Account**

Plan Year Maximum of $5,000.00 ($2,500.00 if married but filing separate tax returns)

☐ I want to contribute a total of $__________ during this Plan Year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

## Employer Contributions

☐ My employer will contribute a total of $__________ during this Plan Year to my Medical Flexible Spending Account.

☐ My employer will contribute a total of $__________ during this Plan Year to my Dependent Care Flexible Spending Account.

**Note:** The employer can contribute up to $500 to all eligible workers without the employee contributing. When employer is contributing an amount over $500, the employer's contribution cannot exceed the employee's election. Employer contributions are not considered part of the maximum employees can contribute.

## Signature

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited unless my employer allows up to $500 dollars to roll in to the next Plan Year.

_______________________________________________ ____________________

Signature Date

**Member: Please return this form to your employer.**

**Employer: Please enter the member's enrollment information through the Further Online Service Center at hellofurther.com.**