2018 ENROLLMENT AND CHANGE FORM: FLEXIBLE SPENDING ACCOUNT (FSA)

City of Springfield — Employer

1/1/2018 — Effective Date

On-file

Employee: Last Name | First Name | Middle Initial | Social Security Number

Employee: Mailing Address (Street) (City) (State) (Zip)

Work Phone _____ **Or** Home Phone _____

Primary Beneficiary _____ Relationship _____

I authorize the following annual FSA election amount(s) for plan year covering 1/1/2018-12/31/2018:

	Per Pay Period Amount (Annual amount divided by 26 pay periods)	**Annual Amount**
EXAMPLE:	*$ 52.00*	*$ 1352.00*
1. Un-reimbursed Health Expense (Out of pocket medically necessary expenses) Annual Maximum $2,650 (NOTE: $500.00 Rollover eligibility for Active Employees to the next plan year.)	$	$
2. Dependent Care Expense (Child Care) Annual Maximum $5,000	$	$
3. Supplemental Premium Account (Not for City deducted premiums)	$	$
TOTAL AUTHORIZED ELECTION:	$	$

Flexible Spending Account

I hereby certify the above information to be correct and true to the best of my knowledge and that the children for whom I will be claiming dependent expenses or child care, either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the Plan Year will be forfeited in accordance with current plan provision and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a qualified Change in Status, if my Plan allows. I also understand that the above reductions may correspondingly reduce my future Social Security Benefits.

Signature _____ **Date** _____

AUTHORIZATION