EMPLOYEE BENEFIT SYSTEMS
HELPING ADMINISTER YOUR SUCCESS

# Enrollment Form
## FSA, LFSA, DCA

**Personal Information**

**Open Enrollment:** ☐ **Mid-Year COVID-19:** ☐ **New Hire:** ☐ **Hire Date:** _____ **Effective Date:** _____

**Employer Name:** _____ **Division:** _____ **Date of Birth:** _____

**Participant Name:** _____ **Social Security Number:** _____ - ____ -

**Address:** _____ **City:** _____ **State:**_____ **Zip Code:**_____

**Email:** _____ **Phone:**

☐ The benefits of medical and dependent care Flexible Spending Accounts have been thoroughly explained to me and I **decline** to participate but wish to have my premiums paid pretax.

**Medical Flexible Spending and Dependent Day Care Election**

I authorize payroll deductions from my earnings per pay period on a pre-tax basis and request my salary be reduced and allocated to the benefits selected. I understand this election cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Plan Document. I further understand that any amounts remaining in my account at the end of the plan year will be forfeited and not returned to me. Eligibility to participate ceases on the date of termination and debit cards will be disabled. Manual claims for eligible services incurred prior to the termination date will be reimbursed during the run out period as specified in the Plan Document.

| Benefit | Covers unreimbursed expenses not paid by other plans | # Payrolls | Employee $ Per Payroll | Annual Election |
|---|---|---|---|---|
| **FSA** **$2,750 Max** | **General Purpose Flex Spending Account:** Medical, Dental, Vision and eligible OTC supplies. Check with employer for maximum amount allowed annually. | | | |
| **LFSA** **Compatible with HSA Plans** **$2,750 Max** | **Limited Purpose Flex Spending Account:** Dental and Vision ONLY. If you, your spouse or dependents make or receive contributions to a Health Savings Account (HSA), you are not eligible to participate in a General-Purpose FSA. You may participate in a Limited FSA. | | | |
| **DCA** **$10,500 Max** | **Dependent Day Care Account:** Maximum DCA $5,250 if married and filling taxes separately, or $10,500 if single or married filing jointly. **Applies to calendar year 2021 only.** | | | |

**Direct Deposit Authorization**

I hereby authorize Employee Benefit Systems to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This authorization shall remain in force until revoked by me. I have read and understand the information on this form regarding direct deposit of reimbursements.

**This agreement is: On File :** ☐ **New:** ☐ **Change:** ☐ **Cancel:** ☐ **Account Type: Checking:** ☐ **Savings:** ☐

**Account Number:** _____ **Routing Number (9 digits):**_____

**Name of Bank:** _____ **Bank Address:** _____

**PHI Authorization**

I hereby give EBS permission to disclose medical information to my spouse or dependents that use my Flex account for verifying the eligibility of transactions or offsetting ineligible transactions. I understand that this may involve medical, dental and vision services. I further understand that if the person or entity that receives information is not a health care provider, health plan, or clearing house covered by the federal privacy regulations or business associate of these entities, the information may be re-disclosed and no longer protected by the regulations. I understand Flex benefits could cover the family, and that these funds should only be used for services that could be disclosed to another family member. I understand that this authorization is valid until revoked and will not expire unless received in writing at EBS.

**Employee Certifications**

I certify that I will only claim reimbursement or use my EBS Flex debit card for eligible expenses for myself and /or qualified dependents. I understand that I am required to keep all itemized receipts/statements. I further certify that these expenses will not be reimbursed under any other benefit plan. I recognize that any ineligible expenses charged to my flex debit card represent an overpayment of my salary or wages and that I must repay my employer immediately. My employer may deduct any erroneous claims reimbursements or debit card transactions from my salary or wages. If my employment is terminated for any reason, the entire amount of any remaining ineligible charges will be due and payable immediately. My employer may apply unpaid ineligible transactions as a debt against my final payroll without any other notice. By accepting and using my flex debit card, I am agreeing to the terms and conditions contained in the Cardholder Agreement, including any amendments thereto, which will govern the use of the card.

**I have examined this agreement and to the best of my knowledge, it is true, correct and complete.**

**Employee Signature:** **Date Signed:**

**Employee Benefit Systems - 214 North Main Street, Burlington, IA 52601**
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