Employee Flexible Spending Account Enrollment Form

EMPLOYER: CSULB Research Foundation			GROUP NUMBER: AOA00003	
EMPLOYEE INFORMATION				
LAST NAME:		FIRST NAME:		MI:
ID # / SSN:		SEX: ☐ M ☐ F		
DATE OF BIRTH (MM/DD/YYYY):		DATE OF HIRE (MM/DD/YYYY):		
EMPLOYEE ADDRESS: ☐ Please check if this is a change in address				
STREET ADDRESS:				
CITY:		STATE:		ZIP:
E-MAIL ADDRESS:		FAX NUMBER:		
HOME PHONE:		WORK PHONE:		

ELECTION

I ELECT THE FOLLOWING:		Amount Per Pay Period	# of Pay Periods	Annual Election	
				Actual	Maximum
Healthcare Account:	☐ Yes ☐ No	$		$	$ 2,700 Plan Year
Dependent Care Account	☐ Yes ☐ No	$		$	$ 5,000 Calendar Year

Pre-Tax Premium Deductions: health insurance premiums, and all other eligible insurance premiums, will be excluded from taxable income. The employer will automatically apply pre-taxation of these insurance premiums unless you specifically decline the option. If you do not wish to have your insurance premiums pre-taxed, you must notify Human Resources during open enrollment.

☐ Please check this box if you have lost, misplaced, or need a replacement FSA Benefits Card for the new Plan Year. If you currently have an FSA Benefits Card, you do not need a new one. Your current card will be "re-loaded" at the start of the new Plan Year.

QUALIFIED DEPENDENTS

The following lists the IRS qualified dependents whose claims I may request reimbursement for throughout the Plan Year:

LAST NAME	FIRST NAME	RELATIONSHIP TO EMPLOYEE

AUTHORIZATION

By signing this form, I certify the following: 1) I have read the information provided to me on Flexible Benefits. 2) The above information is correct and I authorize the salary reductions as I have indicated. 3) I understand that any amounts remaining in my Health Care Account that are not used for eligible expenses incurred during the plan year may be subject to forfeiture, according to plan provisions and pre-tax laws – see SPD 4) I understand that any amounts remaining in my Dependent Care Account that are not used for eligible expenses incurred during the plan year may not be carried forward, according to plan provisions and pre-tax laws.5)I understand that the elected salary reduction(s) will remain in effect for the Plan Year and can only be changed if I experience a change in my status (e.g. birth, adoption, marriage, divorce, loss or gain of spouse's employment), according to the Summary Plan Document.

EMPLOYEE SIGNATURE (Required) _____ DATE _____

INFORMATION SUPPLIED BY EMPLOYER:					
Frequency of Pay:	☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly	☐ Other
First Pay Date of Deductions:			Division/Location:		
Effective Date Of Coverage:					

Managing your reimbursement account has never been easier! For instant access to your account, register with My SmartCare's online portal at https://www.mywealthcareonline.com/bccsmartcare/ or download the free My SmartCare mobile app from your Apple or Android device.