Flexible Spending Enrollment Form

Employee Benefits Corporation

EBC phone Number: 800-346-2126 or 608-831-8445

Plan Dates

Plan Year	No. of Pay Periods

Employee Information (Please Print Legibly)

Employee's Name	Date of Birth	Social Security Number

Home Address

Home Phone

Email Address (we do not share your email address)

Plan Benefits

Group Insurance Premiums (Health, Dental, Basic Life Insurance)

You are ***Required*** to Check One Box

☐ **Pre-tax**

☐ **After-tax**

IMPORTANT: If you do not return this form, your group insurance premiums will be deducted on a **Pre-Tax Basis.**

Are you or your family members participating in a Health Savings Account (H.S.A.)? ☐ Yes ☐ No

Standard Flexible Spending Account

For those enrolled in Low Deductible Health Plan $ [ ] ÷ [ ] = [ ]

(Out-of-pocket expenses for medical, dental, vision, etc.) Plan year election amt | No. of Paychecks | Amount per Paycheck

Yearly Minimum amount is $100; Yearly Maximum is $2650; Grace Period Applies

Limited Flexible Spending Account **ONLY FOR THOSE WITH HSA ACCOUNTS**

For those enrolled in Health Savings Account $ [ ] ÷ [ ] = [ ]

(Out-of-pocket expenses for dental, vision, only) Plan year election amt | No. of Paychecks | Amount per Paycheck

Yearly Minimum amount is $100; Yearly Maximum $2650; Grace Period Applies

Dependent Day Care Expenses

OR $2550 if married and file separate tax Returns — Plan year election amt | No. of Paychecks | Amount per Paycheck

Yearly minimum amount is $100; Grace Period Applies

Direct Deposit (optional: complete banking information below to participate - authorization is in effect from plan year to the next)

Financial Institution | City | State | Zip

☐ Checking ☐ Savings

Account Number | Routing Number (exactly 9 digits)

Signature and Acknowledgement

This agreement will remain in effect for the Plan Year unless changed for reasons stated in the terms and conditions of the Plan (see HR or Dodge County HR webpage for details). By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the Qualifying event. I agree to hold Employee Benefits Corporation and my employer harmless from any liability to my participation in this plan.

Employee Signature

Date