2024 Flexible Spending Enrollment

Your election applies to the Plan Year: 01/01/2024 – 12/31/2024.
To continue in the Plan, you must re-enroll each year.

If form is not returned by due date, coverage will be waived.

EMPLOYEE INFORMATION

Employee Name: _____

Social Security Number: _____-_____-_____ Phone Number: (_____) _____

Address: _____

City, State, Zip: _____

Date of Birth: _____/_____/_____ Email Address: _____

FSA Benefit Election	Yearly Minimum/Maximum Grace Period Applies	Per Pay Period Amount	Pay dates per year	Total Annual Amount
☐ Standard Flex Spending(*For those without Dodge Co Health Insurance*) Out of pocket expenses for medical, dental, ,vision, pharmacy	$100/$3200		24	
☐ Limited Flex Spending (*For those with HSA*) Dental & Vision Only	$100/$3200		24	
☐ Dependent Day Care Expenses	$100/$5000 per family or $2500 if married and filing separately		24	

DIRECT DEPOSIT ELECTION: (Complete this section if you want Direct Deposit of your reimbursement)

Type of Account (Check One): ☐ Checking ☐ Savings

Name of Bank:_____

Routing Number:_____ Account Number: _____

PRE TAX OR POST TAX: YOU ARE REQUIRED TO CHECK ONE BOX

Would you like your benefits deducted as: ☐ Pre Tax ☐ Post Tax

****If form is not returned, group insurance premiums will be deducted on a Pre-Tax Basis.**

ACCEPT COVERAGE

This agreement will remain in effect for the Plan Year unless changed for reasons stated in the terms and conditions of the Plan. By affixing my signature below, I certify that I have examined the BESTflex Summary Plan Description (see Human Resources webpage - www.co.dodge.wi.us) 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 of this plan.

_____ _____

Employee Signature Date

WAIVE COVERAGE

☐ Waive Coverage I understand that I am eligible to apply for the Flex Spending Program though Dodge County. I choose not to participate and hereby waive coverage.