# Flexible Spending Healthcare & Dependent Care Enrollment

**Instructions**
Complete this form in order to open an Flexible Spending Account. Forward the completed form to your **Benefits** office.
If you have any questions regarding this form, please contact **Benefits**. 713-2249

Group Name: **Oklahoma County** Group #: **JSLOC** Plan Year: **1/1/2024 - 12/31/2024**

*Employee Name: ____________________ *Social Security Number: ____________________

*Address: ____________________ Email Address: ____________________

*City: ____________________ Gender: ______ Female ______ Male

*Home Phone: ____________________ *State: _______ *Zip: __________ *Date of Birth: ____________________

____________________ Cell Phone: ____________________

_____Yes, I am enrolling in the Flexible Spending Account

_____No, I am not enrolling in the Flexible Spending Account

| | **Per Pay Period Election:** | **Annual Election:** |
|---|---|---|
| **Healthcare Reimbursement Enrollment:**<br>***(Notes: Do not include premium contributions in this amount. See your employer for minimum and maximum amounts allowed.)***<br>Total Amount Desired to Fund Healthcare Flexible<br>Spending Account (min. annual election) $ N/A<br>Spending Account (max. annual election) $ 2,400 | $ ____________________ | $ ____________________ |
| **Dependent Care Reimbursement Enrollment**:<br>***(i.e., preschool, after school childcare, dependent daycare, etc.)***<br>Total Amount Desired to Fund Dependent Care Flexible<br>Spending Account (max. annual election $5,000) | $ ____________________ | $ ____________________ |

Include Debit Card ☐ Yes ☐ No **(If you already have a card, please do not check a box, see card regarding expiration date) Additional cards may be ordered for dependents over the age of 18, please list the dependent information below in order to receive the additional cards (fee may apply):**

Name(s); Date(s) of Birth (DOB); and Relationship of Dependents (including Spouse). If additional space is needed, please use back of form.

Name: ____________________ DOB: ____________ Relationship: ____________

Name: ____________________ DOB: ____________ Relationship: ____________

Name: ____________________ DOB: ____________ Relationship: ____________

**Debit Card Authorization Agreement (if elected above):** The Plan requires a certification upon enrollment and each plan year thereafter that the debit card will only be used for eligible expenses of the employee and the employee's spouse and dependents. As the plan participant, I certify that any expense paid with the debit card has not been reimbursed and that as the participant I will not seek reimbursement under any other plan covering these benefits. As the Plan participant, I also agree to acquire and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts and will submit them to HealthSmart as required per the IRS' documentation standards to validate my purchase. I further certify that if I should purchase items using my debit card that are not deemed to be eligible expenses, I authorize my employer, or HealthSmart on my employer's behalf, to collect the improper payment from me. If this option is unsuccessful, I understand that I will be denied access to the card's usage until the debt is repaid by me.

**Enrollment Authorization:** By signing I certify that I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the plan year this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. I understand that, except for certain family situations as defined by the SPD, my participation in this Plan is for the entire Plan Year. I understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease. I understand this redirection may have minimal effect on my Social Security Benefits. I understand that amounts redirected into this account may not be used in any other benefit plan, refunded or carried over to the following year. Reimbursement will be available only for qualified health care expenses as described in the Summary Plan Description. I agree to notify my employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. Prior to the beginning of each Plan Year, I will be given an opportunity to change the amount of my election or revoke my participation. If I do not submit a new election, my coverage will end with plan year of this election. The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Service. This agreement is subject to the terms of the Employer's Flexible Benefit Plan as may be amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under the applicable laws, and revokes any prior election and salary reduction agreement (if any) relating to such a plan.

____________________ ____________
Employee Signature Date

**Administrative Use Only**

**Division** ____________ **Location** ____________ **Hire** ____________ **Effective Date:** ____________

**First Deduction Date:** ____________ **Payroll Frequencies:** ____________

____________________ ____________________
**Benefits and Retirement Dept. Signature** **Date**