AULTCARE

UNION HOSPITAL.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT
ENROLLMENT FORM 2019

Employee Name _____ID#_____

Email Address_____Daytime Phone_____

$2,650 Maximum per year

I hereby authorize UNION HOSPITAL. to reduce my earnings for the 2019 plan year by $_____ per pay (x 24 pays) for a total of $_____ for deposit into my Health Care Flexible Spending Account (FSA) to make this money available to me for reimbursement of qualified out-of-pocket expenses.

I understand that I will forfeit any unused balance in my account at the end of the the plan year **and/or 2 ½-month grace period** . I also understand that I cannot change my plan participation unless I have a qualified change in family status, as defined by the Internal Revenue Service Code Section 125.

I authorize my employer to withdraw the amount listed above for the direct deposit into my FSA.

Signature_____**Date**_____

Please provide me with the following number of Flexible Spending Debit Cards _____

_____

Bank Account Information

Bank Name _____

Routing Number _____

Account Number _____

Account Type (Circle One) Checking Savings ***Attach a copy of a voided check ***

****Be advised, your FSA may only be used on qualified out-of-pocket expenses after all other health insurance has been considered. If your plan includes a Health Reimbursement Account (HRA), it must be exhausted prior to using your FSA. If you participate in a Health Savings Account (HSA), certain expenses may not be eligible under your FSA. Please contact your tax advisor. ****

Note: Salary reductions are credited to your account on a per-pay basis. Your salary reduction is made on a pre-tax basis, in accordance with the IRS Section 125 Guidelines.