# 2022 Flexible Spending Account (FSA) Enrollment/Change Form

## Health Care Account  Dependent Care Account

**To enroll or change, complete the Enrollment Form in full.**

**Plan Year Beginning**: _____ through December 31, 2022  **Employee Number**: _____

**Social Security No.**: _____ **Hire Date**: _____ **Telephone**:_____

**Employee Name**: _____ _____ _____
(Please Print) First Name Initial Last Name

### To be completed by Employee

**Health Care Flexible Spending Account** (HCFSA)

**Your Election Amount**
CANNOT EXCEED $2,750.00
=$_____.____

***Dependent Care Flexible Spending Account** (DCFSA)
(For work-related, tax-dependent day care expenses)

**Your Calendar Year Election Amount**
* CANNOT EXCEED $5,000 PER HOUSEHOLD
=$_____.____

### To be completed by Benefits

**Pre-tax Contribution Per Pay**
=$_____.____

**Number of deductions in Plan Year**
X _____

**Pre-tax Contribution Per Pay**
=$_____.____

**Number of deductions in Plan Year**
X _____

**FSA Effective Date**:_____ **First Pay Check with Deduction**: _____

Want to learn how to save money on Health Care and Dependent Care Expenses?
Visit Health Equity/WageWorks'website at **wageworks.com/eligible-expenses** or call **877.924.3967**

* For the Dependent Care FSA Account, the maximum annual IRS contribution is the lesser of $5,000 for married filing jointly; or $2,500 for married filing separate. If you are single, the maximum dependent care annual election is $5,000.

**I ELECT TO PARTICIPATE in a Summa Health FSA Plan and agree to be bound by the terms of the Plan. I understand the following**:

- Contribution(s) I have elected will be made with pre-tax salary reductions each pay and that such deductions reduce my compensation for Social Security benefit purposes.
- This agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement.
- I am making a binding election for the entire Plan Year unless I have a qualified change in status as defined by the Plan. Any salary reductions over $500.00 that have not been used for Health Care expenses incurred in the current Plan Year (noted above) will be forfeited. If I terminate from the Plan within the Plan Year, I acknowledge that I have 60 days from the date that my FSA terminates (which is the last day of the month of my last day worked, or plan termination due to a qualifying event, or my transfer into a benefit in-eligible position) to remit eligible FSA expenses incurred within the Plan Year up to the date of my FSA termination.
- If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the FSA Plan Document, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

I have reviewed the terms of the FSA Plan. I understand that I may elect coverage under either or both of the accounts above, subject to the terms of the 2022 Plan Year.

**Employee Signature**: _____ **Date**: _____

Return your completed form to Benefits Administration, **summabenefits@summahealth.org**.