Flex Spending Account Enrollment Form

Plan Year _____ Plan Entry/Start Date:_____

_____ _____
Employer Name Location/Division/Branch

_____ _____
Employee Name Social Security Number

_____ _____ _____ _____
Address City State Zip

Email Address_____ ☐ Direct Deposit? Complete back side of form

---

Please check appropriate box and complete HCFSA &/or DCFSA election amounts, even if $0, then sign, date & return form to Employer.
Your cost of insurance premiums is calculated based on the benefits you've elected and withheld pre tax. There is no fee for this.
If you do not want to have your premiums withheld pre tax, you must notify payroll in writing prior to the plan start date*

☑ Pre Tax Premiums Automatically
(see employer for specifics)

☐ I wish to Enroll in the Health and/or Dependent Care FSA Categories as listed below.

Flexible Spending Accounts	Annual Election Amount
Health Care Flexible Spending Account (HCFSA) See Employer for Plan Year maximums	$_____
Dependent Care Flexible Spending Account (DCFSA) Plan/Calendar/Household max is $2500/$5000 (see Guide for important info)	$_____
Applicable Group Insurance Premiums are Deducted Pre Tax Your share of the premiums is calculated by the benefits you elect.	Automatically Tax Free

Please see your Employer to determine what, if any, fee is applicable if you participate in an FSA

Election and Salary Reduction Agreement

I hereby authorize my employer to reduce my cash compensation as indicated above for the Plan Year following the date of this agreement. This total amount will be divided by the number of pay periods, and may be adjusted to meet the annual election amount if a pay cycle is missed. The funds can be accessed for reimbursement by submitting claims to the plan for eligible expenses. (I have elected to have my cost of premiums withheld tax free – however I understand those premiums are not reimbursable. The Payroll Department will calculate my contribution based on the benefits I have enrolled in).

I understand that this election form, for both the FSA categories as well as my eligible group insurance premiums, cannot be revoked or changed during the plan year, unless there is a qualifying change in status (e.g. marriage, divorce, death of a spouse/child, birth or adoption of a child, or termination of employment - see plan documents) which justifies the revocation or change.

I understand that if any unused contributions remain in the account at plan year end & subsequent grace period, the IRS "use it or lose it" rule applies and those funds will be forfeited. I understand that all expenses must be incurred during the plan year in order to be considered eligible (see plan documents to see if plan has optional extension). Incurred is the date the services were rendered, not the date the expense may have been paid or billed. I know that each year I have the option to change my elections during the Open Enrollment Period (OEP). If I do not submit changes, in writing, during the OEP, my elections *may* remain the same for the new plan year (see plan documents for your plan specifics). Eligible insurance premium changes each year are automatically withheld pre tax. I can opt out of having my eligible insurance premiums withheld pretax, if I submit such request to payroll prior to the beginning of the plan year or before first deductions are taken.

_____ _____
Participant's Signature Date

☐ *If you do not want your eligible insurance premiums withheld pre tax, initial box & return form to employer. The Premium Conversion Plan is administered by your employer and simply deducts your share of the premiums on a pre tax basis.

PAYPRO ADMINISTRATORS
6180 Quail Valley Court, Riverside, CA 92507
800.427.4549 951.656.9273 Fax 951.656.9276
Email: flex@pagroup.us www.pagroup.us
Rev 2/12

Direct Deposit Authorization Form – Flexible Spending Account Reimbursements

To assure prompt and accurate processing of your request, please return this form either to your employer, fax it to (951) 656-9276, email it to flex@pagroup.us or mail it to:
PayPro Administrators
6180 Quail Valley Court, Riverside, CA 92507

Employer Name

Complete this Section for any/all Direct Deposit Requests.
Then Check box below & complete that section

Employee Name

SSN

☐ *To Enroll in Direct Deposit, check box, attach voided check, & complete: (deposit slips not acceptable)*

Bank Name | Routing Number | Account Number

Authorization – I hereby authorize PayPro Administrators and my Bank, as indicated on the attached check, to initiate entries into my designated account.

If my Bank is ever notified by PayPro Administrators that funds, to which I am not entitled to, have been erroneously deposited into my account, I authorize my Bank to return such funds to PayPro Administrators.

Signature | Date

☐ *To Change Your Bank & Direct Deposit, check box & attach voided check: (deposit slips not acceptable)*
(complete the top section of this form)

Bank Name | Routing Number | Account Number

Authorization – I hereby authorize PayPro Administrators and my Bank, as indicated on the attached check, to initiate entries into my designated account.

If my Bank is ever notified by PayPro Administrators that funds to which I am not entitled to have been erroneously deposited into my account, I authorize my Bank to return funds to PayPro Administrators.

Signature | Date

☐ *To Cancel Direct Deposit, check box & complete below.*
(also complete the top section of this form)

My signature below, indicates that I wish to cancel direct deposits. I understand that a 30 day notice is necessary, prior to the cancellation date.

Signature | Date

PAYPRO ADMINISTRATORS

800-427-4549 . 951-656-9273 . Fax 951-656-9276
6180 Quail Valley Court, Riverside, CA 92507
www.pagroup.us . Email flex@pagroup.us
Rev. 2/12