METROCORP

2015 Flexible Spending Account Enrollment Form
FSA Benefit Year Start Date: January 1, 2015
FSA Benefit Year End Date: December 31, 2015
Please complete this form and submit it to your Department Head

INSTRUCTIONS

Complete this form only if you wish to participate in a Medical or Dependent Care Flexible Spending Account (or both) during the 2015 FSA benefit year. **Please Note:** *Participants in the HSA medical plan may only elect a Limited Use Medical Flexible Spending Account and/or a Dependent Care Flexible Spending Account for the 2015 FSA benefit year.*

The contribution amounts listed below are annual amounts. When you make your election below, the amount you enter into the space provided is the annual amount you wish to contribute to your account(s). Deductions will be made from your salary based on the amount you elect and the number of pay periods remaining until the FSA Benefit Year End Date (December 31, 2015).

EMPLOYEE PROFILE (Please Print)

Effective Date: _____ **Social Security #:** _____

Employee Name: _____ **Daytime Phone #:** _____

Address Line 1: _____ **Employee #:** _____

Address Line 2: _____ **Email Address:**

City, State Zip: _____

MEDICAL FSA ELECTION

To elect a Medical FSA, please indicate below the annual dollar amount that you would like to contribute to your account. **The minimum annual contribution is $0; the maximum annual contribution is $2,550.**

☐ **Waive Coverage** ☐ **Yes**, I would like to elect a Medical Flexible Spending Account. I wish to contribute $_____ this plan year.

LIMITED USE MEDICAL FSA ELECTION – *HSA MEDICAL PLAN PARTICIPANTS ONLY*

Participants in the HSA medical plan are eligible to elect a Limited Use Medical FSA. To elect a Limited Use Medical FSA, please indicate below the annual dollar amount that you would like to contribute to your account. **The minimum annual contribution is $0; the maximum annual contribution is $2,550.**

☐ **Waive Coverage** ☐ **Yes**, I would like to elect a Limited Use Flexible Spending Account. I wish to contribute $_____ this plan year.

DEPENDENT CARE FSA ELECTION

To elect a Dependent Care FSA, please indicate below the annual dollar amount that you would like to contribute to your account. **The minimum annual contribution is $0; the maximum annual contribution is $5,000.**

☐ **Waive Coverage** ☐ **Yes**, I would like to elect a Dependent Care Flexible Spending Account. I wish to contribute $_____ this plan year.

AUTHORIZATION

I hereby authorize these elections for FSA Benefit Year 2015. I authorize Metro Corp to reduce my salary by the agreed upon amount as indicated in the benefits booklet to pay premiums for myself and/or my dependents. Before the start of each plan year, I will be provided with the opportunity to change my benefit election for the new plan year. If I do not complete this form and submit a new election at that time, my Flexible Spending Account(s) will be closed and no deductions will be taken during the new plan year.

As stated above, Flexible Spending Account participants must complete a new enrollment form each year. December 31 closes and cancels the 2015 Flexible Spending Account election(s).

Signature **Date** **Work Phone Number**