Employee Flexible Spending Account (FSA) Enrollment Form

PacificSource ADMINISTRATORS

Please print responses. * = required field

1. Employment information

Employer* _____ Division/class _____

Hire date* _____ FSA effective date* _____ First deduction date _____

PSA member ID (if applicable) _____ Employee ID _____ Hours worked per week _____

2. Employee information

Employee first name, MI* _____ Last name* _____

Social Security #* _____ Email _____

Mailing address* _____

City* _____ State* _____ Zip* _____

Home phone _____ Mobile phone _____

Date of birth* _____ Beneficiary name and relationship _____

3. Premium payment component

☐ I agree to have my salary reduced on a pretax basis to pay the premiums offered by my employer for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 for myself and my eligible family members. *If my employer uses the evergreen method of enrollment, I will remain enrolled in the Premium Payment Component until I notify my employer in writing that I do not wish to have my share of the premium(s) deducted on a pretax basis.*

4. Flexible spending account election

	Account (as offered)	Employee pay period election	Number of pay dates		Employee annual election	Account information
DCAP component	Dependent Care Expenses (DCE)	$	x	= $		Childcare expenses (for dependents younger than 13) and elder care expenses you incur while at work or school.
Health FSA component	General-Purpose Health FSA (HRE)	$	x	= $		Eligible medical, dental, vision, and preventive expenses for yourself and your dependents.
	Limited-Purpose Health FSA (LFSA)	$	x	= $		Eligible dental, vision, and preventive expenses for yourself and your dependents. Employees contributing to a health savings account may elect this plan.
	Limited-Scope Health FSA (LSFSA)	$	x	= $		Eligible dental and vision for yourself and your dependents. Employees ineligible for the group-sponsored medical plan may elect this plan.

☐ Check here if you or your dependents are enrolled (or plan to enroll) in a health savings account.

☐ Check here if you are not eligible (or won't be eligible) in your employer's group sponsored medical plan.

Continued >

5. Dependent information

If you enroll in the dependent care component, the names and ages of your dependents are required.

Dependent name _____ Social Security # _____ Date of birth _____

Dependent name _____ Social Security # _____ Date of birth _____

6. Optional features

Optional features may not be available for all plans. See your plan summary or ask your employer for additional information. If available, you may elect the benefit debit card. If you are enrolled in your employer's PacificSource plan, you may be eligible for the EasyPay program. FSA claims may still be submitted via fax, mail, or electronically through our FSA/HRA portal at PSA.PacificSource.com. **Select one from the following choices:**

Benefit debit card	A benefit debit card deducts directly from your health FSA at the point of sale. Itemized receipts are required for all transactions that are not auto-substantiated at the point of sale. There is no additional cost to acquire your initial benefit debit card. Upon expiration (5 years) a new set will be automatically mailed for no additional fee. *Select if you would like to enroll and/or remain enrolled, or disenroll.*	☐ Enroll and/or remain enrolled ☐ Disenroll
Replacement benefit debit card	A set of two replacement/additional benefit debit cards are available for a fee of $10. This fee is deducted from your health FSA account. Please indicate if your cards have been lost or stolen (and if you would like to replace your cards with new numbers). Or indicate if you would like to order additional cards with the same card number.	☐ Lost/stolen ☐ Additional
EasyPay	EasyPay is the automatic reimbursement of eligible claims processed by PacificSource Health Plans. Employees must be enrolled in their employer's PacificSource plan to be eligible for EasyPay. Employees or their family members with secondary coverage are not eligible for EasyPay. In order to be enrolled, an EasyPay enrollment form must be signed and returned. The EasyPay form is available at PSA.PacificSource.com/forms.	

7. Participant authorization or waiver

☐ **Participant authorization**

I hereby certify the information provided on this form is correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the plan year may be forfeited in accordance with current Plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the plan year and cannot be revoked unless I experience a qualified change in status. I also understand that the reductions may correspondingly reduce my future Social Security benefits.

If I lose coverage under the health FSA component as a result of a qualifying event (for example, termination of employment or cessation of eligibility because of a reduction in hours of employment), I may be entitled to elect coverage continuation under the health FSA allowed by my employer's Plan. I understand that I cannot be forced to repay or voluntarily repay the employer for any amounts exceeding my health FSA account balance.

☐ **Participant waiver**

I do not wish to participate in the Plan and waive enrollment for the health FSA Component, DCAP Component, and Premium Payment Component. I understand that by refusing to participate, I will be unable to enroll this plan year unless my employer allows mid-year changes and I experience a qualifying event, in accordance with the IRS Code Section 125, and submit the change within 30 days of the qualifying event.

Any person who, with an intent to knowingly defraud, files this application with materially falsified information or conceals material information, may be subject to criminal and civil penalties and PacificSource Administrators, Inc. may cancel such person's membership and refuse to pay their claims.

Employee signature* _____ Date _____

Employee: *Please return the original to your employer and retain a copy for your records.*
Employer: *Please audit the form, retain a copy for your records, and forward a copy to PacificSource Administrators, Inc. or submit a spreadsheet electronically.*

PacificSource Administrators, Inc. PO Box 70168, Springfield, OR 97475; **800-422-7038,** TTY: 711 (we accept all relay calls); fax 800-575-1109; PacificSource.com/PSA