Baldwin-Whitehall School District

FSA Medical and FSA Dependent Care **July 1, 2020 through June 30, 2021**

Consumer Profile

First Name:		Phone No:	○ Home ○ Cell ○ Work
Middle Initial:		Phone No:	( ) -
Last Name:		Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___
Social Security No:		Gender:	○ Male ○ Female
Email Address:		Marital Status:	○ Married ○ Single
Address Line:		Date of Hire:	___ ___ / ___ ___ / ___ ___ ___ ___
City:		Effective Date	07/01/2020
State:		Payroll Frequency:	○ Week ○ Bi-Week ○ Semi-Mo ○ Month
Zip:		Division:	n/a

Dependent(s) Profile

First, Last Name:		Relationship:	○ Spouse ○ Dependent
Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___	Full Time Student:	○ Yes ○ No
First, Last Name:		Relationship:	○ Spouse ○ Dependent
Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___	Full Time Student:	○ Yes ○ No
First, Last Name		Relationship:	○ Spouse ○ Dependent
Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___	Full Time Student:	○ Yes ○ No

Enrollment

By this signed enrollment form, I hereby request that my pay be reduced throughout the plan year per my elected amount below.

FSA Medical: Maximum Annual Election - $2,750 (Min - $120)	Per Pay Amount	$_____	Annual Election:	$_____
FSA Dependent Care Maximum Annual Election - $5,000	Per Pay Amount	$_____	Annual Election:	$_____

Debit Card

You will be receiving two debit cards with the consumer's name embossed on both for you and your eligible dependents to use to pay for eligible expenses. By this signed enrollment form, I hereby understand that the debit card is a payment convenience only, and I agree to submit itemized statements and/or Explanation of Benefits to provide proof of expense eligibility as requested by Corporate Coverage TPA.

Reimbursement

Please provide banking information for direct deposit of reimbursement funds. If available, please attached a voided check. If a voided check is not available, please complete the following.

Bank Name:		Routing Number:	
Account Type:	○ Checking ○ Savings	Account Number:	

Authorization and Request for Coverage

I hereby request to enroll in the Benefit Plan(s) for which I am eligible under the plan created by the above Plan Sponsor, (1) affirm that I will abide by the provisions set forth in the How it Works, Summary Plan Description and Plan Document, and (2) certify the above information to be true and correct to the best of my knowledge and that dependents listed above are my legal dependents. I further understand that I may not revoke or change my participation in this plan until the next plan anniversary unless I experience a change in my family status or a change in my or my spouse's employment status.

Signature: X_____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

SIGN HERE ONLY IF YOU DECLINE TO PARTICIPATE IN THE FLEXIBLE SPENDING ACCOUNT.

Signature: X_____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___