INNOVA Benefit Services

ENROLLMENT FORM: PART 2 - ELECTIONS
FSA - Medical Expenses and Dependent Care Expenses

General Information

Baldwin Whitehall School District Flexible Spending Account
July 1, 2018 through June 30, 2019

Participant Information (*Please Print*)

Employee Name:	Social Security Number:
Street Address:	City, State, Zip:
Daytime Phone:	Email Address:

Benefits Election

Medical Expense Reimbursement Account

Maximum Plan Year Election: **$2,650** Minimum Plan Year Election: **$120**	$_____ Per Pay Amount	$_____ Total Plan Year Amount

Dependent Care Expense Reimbursement Account

Maximum Plan Year Election: **$5,000** Minimum Plan Year Election: **n/a**	$_____ Per Pay Amount	$_____ Total Plan Year Amount

*my*SourceCard™ Enrollment Agreement

☐ No, I do NOT want a *my*SourceCard™ debit card.

☐ Yes, I would like a *my*SourceCard™ debit card issued for payment of eligible FSA expenses. **I have read and understand fully that the *my*SourceCard is issued as a payment convenience only, and I am still responsible for verifying all card transactions via acceptable documentation when it is requested or my card may be blocked and payment may be due back to the Plan.** *(If you currently have a mySourceCard™, you can continue to use it in the new plan year.)*

Request for additional card(s)	Name	Relationship

Reimbursements

Reimbursements are made via **direct deposit**. *(If you are currently enrolled in direct deposit, your information will remain in effect.)*

Attach Voided Check Here *(Do NOT attach a deposit slip.)*

Joan Doe
Anywhere, USA

1234

PAY TO THE ORDER OF _____ $ ____

_____DOLLARS

YOUR TOWN BANK
YOUR TOWN, AR 123456

FOR _____ _____

⑆25550005⑆ 1234556789022⑈ VOID

Authorization/Declination

I have been made aware of and understand that all of the appropriate documents relating to the Baldwin Whitehall School District Flexible Spending Account ("Plan") including Page 1 – Plan Highlights of this two-page Enrollment Form, the Summary Plan Description, Privacy Notice, and any other relevant Plan Documents, or Notices are available to me electronically. I also understand that if I wish to receive a paper copy of any of the above documents, I may do so free of charge by contacting my Human Resource Department.

☐ **Authorization:** I elect to participate in the Plan and agree to have my gross salary reduced by the benefit amount(s) selected above. I understand this election is irrevocable for the plan year unless there is a change in family status and that any unused balance(s) may be forfeited pursuant to the rules of the Plan.

☐ **Declination:** I have been given the opportunity to enroll in the Plan, but I elect NOT to participate.

Signature of Employee	Date