HealthCare SOLUTIONS GROUP
P. O. Box 1309 Muskogee, OK 74402
1-800-749-1422

Flexible Spending Account Election Form
For Calendar Year 2015

Please Print

Name:		Social Security Number:
Street Address:	City & State:	Zip Code:
Date of Birth:	E-Mail Address:	Effective Date:
Employer's Name:		

List All Eligible Dependents

LAST, FIRST, MI	REL	BIRTHDATE	SOCIAL SECURITY NUMBER *(Only required if requesting a Debit Card)*
Spouse			
Child			
Child			

My employer and I agree that my pay will be reduced by the amount of my required contribution for the benefit option(s). I have elected under the Flexible Spending Account, and continuing for each succeeding pay period until this agreement is amended or terminated. The annual pledge shown below will be divided by the number of pay periods for the remainder of that calendar year. The amount of my required contribution for each is set forth below.

A. Flexible Spending Account

☐ **Unreimbursed Medical:** Annual Pledge $_____ Per Pay Deduction $ _____
($2,550 Annual Maximum)

☐ **Dependent Care:** Annual Pledge $ _____ Per Pay Deduction $ _____
($2,500 – Single / $5,000 - Family Annual Maximum)

Please elect a reimbursement method:

☐ Flex Debit Card (or)

*☐ I would like reimbursements made automatically from my account.

You may not elect this option if you or any of your dependents have a secondary carrier outside of this Plan or if you elect the Flex Debit Card

☐ I will submit receipts for the bills I would like reimbursed from my account.

The terms of the Flexible Spending Accounts under the section 125 Cafeteria Plan have been explained to me and I have read the descriptive material. I understand my options with regards to elections made under it. I hereby elect the benefits as indicated above and agree to have the pre-tax benefits purchased as an employer contribution on my behalf. I understand that by signing and submitting this enrollment form, that the benefits above will remain in effect for the entire plan year and that this election cannot be revoked or changed during the plan year, unless there is a change in family status (i.e., marriage, divorce, death of a spouse, or birth or adoption of child and termination of employment of a spouse).

Employee Signature:	Date:

For Refusal Only

B. This plan has been explained to me and I choose not to participate this year.

Employee Signature:	Date:

Section A or B above must be complete.

To be completed by Employer

Frequency of Pay: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

First Pay Date of Deductions: _____/_____/_____ ☐ 5% Owner ☐ Key Employee ☐ Highly Compensated Employee