



PEAK ONE

administration

FSA ENROLLMENT FORM

Please return this completed form to your HR Department

Participant Information. Please PRINT Clearly.

Employer Troy School District			Plan Effective Date
Employee's Name (Last, First MI)		Date of Birth	Social Security Number:
Employee's Home Address	City	State	Zip
Employee Email Address			Mobile Phone
<p>As a participant in the employer-sponsored plan, you will receive a free debit card. Debit cards can only be requested for dependents 18 years and older. You can request additional cards online or by contacting our MemberCare Department at membercare@peakoneadmin.com.</p> <p>Participant card: \$0.00 Additional card fee: \$0.00 Replacement card fee: \$10.00</p>			

Direct deposit authorization:

Providing this information authorizes Peak One Administration to initiate credit entries for depositing my FSA and/or DCAP into your account designated above and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Peak One has received written notification from me of its termination in such time and in such manner as to afford Peak One reasonable opportunity to act on it.

<input type="checkbox"/> Checking Account	<input type="checkbox"/> Savings Account
Bank Name:	
Routing Number:	Account Number:

I request the following amounts to be deducted pretax:

Group Medical Premium If you participate in your employer's insurance plan(s) your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department otherwise.

Reimbursement Sections:

Health FSA

Minimum: \$0.00

Maximum: \$3,300.00

Dependent Care FSA

Minimum: \$0.00

Maximum: \$5,000.00

Plan Year Total

Of
Paychecks

\$ Per Pay Check

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☐ **Yes, I want to enroll.** The IRS regulation states four conditions. 1.) Any expenses you incur must be within the plan year. 2.) Any expenses you incur must not be covered by any other source such as insurance. 3.) You must provide proper documentation to receive payment. 4.) You cannot change or revoke your elections during the plan year unless there is a specific Change of Status and your employer allows such changes. Please see the Summary Plan Description. Note: Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice. **Prior to each plan year, I will be offered the opportunity to change my benefit election for the following plan year.** You also agree that you will only use the debit card to pay for eligible expenses. You will not use the card for any medical expense that has already been reimbursed. You will also not seek reimbursement under any other health plan for any expense paid for with the card, and the employee will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card.

☐ **No, I do not want to enroll.**

Signature: X _____ Date: _____