FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Complete and return to your employer

Group Information

Group Name: Jackson County Central ISD #2895 **Wex Group Number:** 46287 ____

Location Name (if applicable): _____

Employee Information

SSN#: _____ **Primary Phone:** _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____ **Date of Birth:** _____/_____/_____

Account Information

Medical Flexible Spending Account:

Plan year maximum _____ (determined by employer, not to exceed IRS maximum of $3050)

Effective Date: January 1st, 2024 **(To be provided by Group Contact)**

☐ I want to contribute a total of $_____during this plan year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Are you or your spouse actively contributing to a Health Savings Account?

☐ No

☐ Yes: Your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met. Contact Further to remove the limit when your deductible is met.

Dependent Care Flexible Spending Account

IRS Maximum: $5000.00 ($2500 if married but filing separate tax returns)

Effective Date: January 1st, 2024 **(To be provided by Group Contact)**

☐ I want to contribute a total of $_____during this plan year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Signature

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year may be forfeited.

Signature: _____ **Date:** _____

Employees: Complete and return this form to your employer.

Send via secured email only:
customerservice@wexhealth.com

Fax to:
866-451-3245

Mail to:
PO Box 2926
Fargo, ND 58108