Flex Spending Account Enrollment Form

Plan Year ______________ First Contribution Date______________ Hire Date:____________

______________________________ Employer Name

______________________________ Location/Division/Branch

______________________________ Employee Name

______________________________ Social Security Number

Cell Phone Number______________________________

______________________________ Address

____________ City ______ State ______ Zip Code

Email Address______________________________

An accurate email is required to ensure proper set up for notices and account access.

☐ Direct Deposit? Complete back side of form

(Reimbursement Checks have a per check fee, so get set up with Direct Deposit to avoid any fees!)

Date of Birth (mm/dd/yyyy)______________________

Please complete HCFSA &/or DCFSA election amounts, even if $0, then sign, date & return form to Employer.

Your cost of insurance premiums is calculated based on the benefits you've elected and is withheld pre-tax. There is no fee for this.

If you do not want to have your premiums withheld pre-tax, you must notify payroll in writing prior to the plan start date*

Flexible Spending Accounts

Annual Election Amount

Are you contributing to a Health Savings Account? (this is a bank account) ___ Yes ____No

Health Care Flexible Spending Account (FSA) $__________________

See Employer for Plan Year maximums - Not eligible to participate if you are contributing to an HSA

Limited Purpose Health Care Flexible Spending Account (LPFSA) $__________________

Those in the HSA can Participate for Dental, Vision, & non Deductible Expenses Only!

Dependent Care Flexible Spending Account (FSA) $__________________

Plan Year max is $5000, but see Guide for important info

Please see your Employer to determine what, if any, fee is applicable if you participate in an FSA. Fee is pre-tax as well

Election and Salary Reduction Agreement

I hereby authorize my employer to reduce my cash compensation as indicated above for the Plan Year following the date of this agreement. This total amount will be divided by the number of pay periods, and may be adjusted to meet the annual election amount if a pay cycle is missed. The funds can be accessed for reimbursement by submitting claims to the plan for eligible expenses. (I have elected to have my cost of premiums withheld tax free – however I understand those premiums are not reimbursable. The Payroll Department will calculate my contribution based on the benefits I have enrolled in).

I understand that this election form, for both the FSA categories as well as my eligible group insurance premiums, cannot be revoked or changed during the plan year, unless there is a qualifying change in status (e.g. marriage, divorce, death of a spouse/child, birth or adoption of a child, or termination of employment - see plan documents) which justifies the revocation or change.

I understand that if any unused contributions remain in the account at plan year end & subsequent grace period, the IRS "use it or lose it" rule applies and those funds will be forfeited. I understand that all expenses must be incurred during the plan year in order to be considered eligible (see plan documents to see if plan has optional extension). Incurred is the date the services were rendered, not the date the expense may have been paid or billed. I know that each year I have the option to change my elections during the Open Enrollment Period (OEP). If I do not submit changes, in writing, during the OEP, my elections *may* remain the same for the new plan year (see plan documents for your plan specifics). Eligible insurance premium changes each year are automatically withheld pre tax. I can opt out of having my eligible insurance premiums withheld pretax, if I submit such request to payroll prior to the beginning of the plan year or before first deductions are taken.

______________________________ Participant's Signature

______________ Date

☐ *If you do not want your eligible insurance premiums withheld pre tax, initial box & return form to employer. The Premium Conversion Plan is administered by your employer and simply deducts your share of the premiums on a pre tax basis.

PAYPRO ADMINISTRATORS
PO Box 5040 Riverside, CA 92517
800.427.4549 951.656.9273
Email: customerservice@pagroup.us www.pagroup.us

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Direct Deposit Authorization Form – Flexible Spending Account Reimbursements

To ensure prompt and accurate processing of your request, please return this form either to your employer, fax it to (951) 656-9276, email it to customerservice@pagroup.us or mail it to:
PayPro Administrators
6180 Quail Valley Court, Riverside, CA 92507

____
Employer Name

Complete this Section for any/all Direct Deposit Requests.
Then Check box below & complete that section

____ ________________________________
Employee Name **SSN**

☐ ***To Enroll in Direct Deposit***, *check box, attach voided check, & complete: (deposit slips not acceptable)*

_____________________ _____________________ _______________________
Bank Name Routing Number Account Number

Authorization – I hereby authorize PayPro Administrators and my Bank, as indicated on the attached check, to initiate entries into my designated account.

If my Bank is ever notified by PayPro Administrators that funds, to which I am not entitled to, have been erroneously deposited into my account, I authorize my Bank to return such funds to PayPro Administrators.

____ _______________________
Signature Date

☐ *To Change Your Bank & Direct Deposit, check box & attach voided check: (deposit slips not acceptable)*
(complete the top section of this form)

_____________________ _____________________ _______________________
Bank Name Routing Number Account Number

Authorization – I hereby authorize PayPro Administrators and my Bank, as indicated on the attached check, to initiate entries into my designated account.

If my Bank is ever notified by PayPro Administrators that funds to which I am not entitled to have been erroneously deposited into my account, I authorize my Bank to return funds to PayPro Administrators.

____ _______________________
Signature Date

☐ *To Cancel Direct Deposit, check box & complete below.*
(also complete the top section of this form)

My signature below, indicates that I wish to cancel direct deposits. I understand that a 30 day notice is necessary, prior to the cancellation date.

____ _______________________
Signature Date

800-427-4549 . 951-656-9273 .
PO Box 5040, Riverside, CA 92517
www.pagroup.us . Email customerservice@pagroup.us
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