



**Surency AdvantagePlus
FSA ENROLLMENT FORM**

Instructions

Complete this form in order to open an FSA. (* = Required Fields)

Accountholder Profile Information

_____ * Last Name, First Name, MI (Please Print)		_____ * Employer	_____ * Social Security Number or Employee ID (EID) as appropriate
_____ * Street Address		_____ * City, State, Zip	_____ * Date of Birth (mm/dd/yyyy)
_____ * E-mail Address		_____ * Daytime Phone Number	_____ * Home Phone Number
* Gender	Male Female	* Marital Status	Married Single
_____ * Hire Date (mm/dd/yyyy)	_____ *Hours Worked Per Week	*Payroll Frequency	Bi-Weekly (26)

***Health Care FSA Election** (Please choose one of the following enrollment options)

I am enrolling in an FSA through my employer. I authorize my employer to deduct my FSA contributions from my pay and forward them to my FSA. *(Please complete the section immediately below)*

I understand the benefits offered under the pre-tax spending program (FSA), however, I choose not to enroll in the program for this plan year. *(Please sign and return)*

Plan Rules: The maximum election is \$2,500 and the minimum election is \$130 annually. Qualified expenses are medical, dental, and vision out of pocket cost for you and your dependents. The Plan Year for the FSA runs from January 1 until December 31. Eligible expenses must be incurred within this time. Claims may be filed up until the last day in February, follow the end of the Plan Year. After the filing limit, balances in excess of \$500.00 will be forfeited. Balances under \$500.00 will carry forward to the next plan year and will not count against the annual election limit in following years.

***Dependent Care FSA (DC FSA) Election** (Please choose one of the following enrollment options)

I am enrolling in a DC FSA through my employer. I authorize my employer to deduct my FSA contributions from my pay and forward them to my DC FSA. *(Please complete the section immediately below)*

I understand the benefits offered under the pre-tax program (DC FSA), however, I choose not to enroll in the program for this plan year. *(Please sign and return)*

Plan Rules: The maximum election is \$5,000 or 2,500 if married and filing separate tax returns and the minimum election is \$130 annually. The Plan Year for the DC FSA runs from January 1 until December 31. Eligible expenses must be incurred within this time. Claims may be filed up until the last day in February, follow the end of the Plan Year. The carryover DOES NOT APPLY to the dependent care FSA plan.

Plan Type	Amount per pay period	# of Payroll Deductions	Annual Election
Health Care FSA	\$_____ x	_____ =	\$_____
Dependent Care FSA	\$_____ x	_____ =	\$_____

If there is a discrepancy between the "per pay period" amount and the "annual election" amount, the "per pay period" amount will be used to enter election amounts

***Surency AdvantagePlus Benefits Card**

Benefits cards may only be used for eligible medical expenses, as defined in Code §213(d) of the Internal Revenue Code and you may not seek reimbursement from any other source for the expenses paid for with the benefits card.



***Reimbursement Method - Choose only one method**

Please select your primary method of reimbursement from your FSA.

Direct Deposit – You will need to provide your bank account information in the Direct Deposit Setup section.

Check – All reimbursements will be paid by sending you a check. If choosing this option, skip the Direct Deposit Setup section.

Note: Surency will not issue a reimbursement check until the sum of your claims reaches \$25.

Direct Deposit Setup

This section is required if you have chosen Direct Deposit as your FSA Reimbursement Method above.

If you have previously signed up for direct deposit, and do not wish to change the banking information Surency has on file from a previous year, there is no need to complete the banking information portion of this form.

	*Account Type	Checking	Savings
_____ *Bank Name			
_____ *Bank Address		_____ *City, State, Zip	
_____ *Routing Number	_____ *Account Number		

***Authorization**

I authorize the direct deposit of funds reimbursed from my Pre-tax Accounts into the bank account specified above. My administrator will continue to use this as my "Account of Record" until notified, in writing, to discontinue use of the account. I understand that direct deposit will continue automatically into each new Plan Year unless I notify my administrator, in writing, of a change. I authorize my bank account to be debited for any reimbursements sent in error or claims denied after reimbursement. I certify that I have read, and understand, the information on this Authorization Form.

By signing I certify that I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the plan year this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. I understand that, except for certain family situations as defined by the SPD, my participation in this Plan is for the entire Plan Year. I understand this redirection may have minimal effect on my Social Security Benefits. I understand that amounts redirected into this account may not be used in any other benefit plan, refunded or carried over to the following year. Prior to the beginning of each Plan Year, I will be given an opportunity to change the amount of my election or revoke my participation if I do not submit a new election. For the premium only plan the prior year's election will remain in effect for the new Plan Year for the pretaxing of premiums ONLY unless I complete a waiver. This agreement is subject to the terms and conditions of my Plan Administrator.

*Employee Effective Date (mm/dd/yyyy)
Complete only if different than plan year effective date.

*Employer Signature

*Date (mm/dd/yyyy)

*Employee Signature

*Date (mm/dd/yyyy)