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2027 Flexible Spending Account FSA/Flex Enrollment Form

ELECTING FLEXIBLE SPENDING ACCOUNT (FSA)

I, for myself and for those of my eligible dependents listed in my enrollment information, hereby agree to abide by the rules, regulations and terms of my employer's group flex plan documents as such documents may be amended. I certify that the information furnished is true and complete to the best of my knowledge. I understand that inaccurate information provided regarding my coverage on other plans, my spouse's access to other coverage, or dependents' coverage under employer provided plans may affect my of claims and my access to insurance.

I understand that the change in my benefits election must be due to and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

Select FSA Plan Type:	Select Pre-Tax Payroll Deduction Amount:
☐ Healthcare FSA (compatible with PPO Plan) ☐ Limited FSA (compatible with HDHP & HSA and only valid for dental and vision expenses)	$_____ **per pay** Minimum: $5.00/pay ($130/year) Maximum: $130.76/pay ($3,400/year)
☐ Dependent Care FSA (child/dependent care)	$_____ **per pay** Minimum: $5.00/pay ($130/year) Maximum: $288.46/pay ($7,500/year*) *Annual limit: $7,500 or $3,750 married, filing separately

I am electing to make a pre-tax payroll deduction the amount(s) above for the flexible spending account (FSA) for 2027.

I understand that this card is valid during my employer's Flexible Spending plan year. I understand that I must keep all receipts for debit card uses in one place, and that I may have to submit them at a later date per IRS Guidelines. I understand that failure to do so when requested may result in suspension of my debit card. I understand that a balance due will be applied to my flex account in which I need to reimburse the Plan and may result in the expense reported as taxable income on my W2.

Signature Date

Print Name

FOR 2027, THE FLEX PLAN ADMINISTRATOR WILL BE LIVELY