

## FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

## Complete and return to your employer

Coation Name (if applicable):	Group Information
Employee Information   SN#:	Group Name:Further Group Number:
SSN#:	Location Name (if applicable):
Last Name:	Employee Information
Street Address:    State:   Zip Code:	SSN#: Primary Phone:
Email Address:	Last Name: Middle Initial:
Account Information  Medical Flexible Spending Account:  Plan year maximum	Street Address:
Medical Flexible Spending Account:  Plan year maximum	City: State: Zip Code:
Medical Flexible Spending Account:  Plan year maximum	Email Address: Date of Birth: /
Plan year maximum	Account Information
Effective Date:	Medical Flexible Spending Account:
□ 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:	Plan year maximum (determined by employer, not to exceed IRS maximum of \$3050)
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:	Effective Date: (To be provided by Group Contact)
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:  (To be provided by Group Contact)  I want to contribute a total of \$	☐ I want to contribute a total of \$during this plan year to my Medical Flexible Spending 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:	I understand this amount will be deducted from my pay throughout the plan year.
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:	Are you or your spouse actively contributing to a Health Savings Account?
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:	□ No
Dependent Care Flexible Spending Account  IRS Maximum: \$5000.00 (\$2500 if married but filing separate tax returns)  Effective Date:	Yes: Your medical FSA must be limited to dental and vision expense reimbursement until your health plan
IRS Maximum: \$5000.00 (\$2500 if married but filing separate tax returns)  Effective Date:	deductible has been met. Contact Further to remove the limit when your deductible is met.
Effective Date:	Dependent Care Flexible Spending Account
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.	IRS Maximum: \$5000.00 (\$2500 if married but filing separate tax returns)
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.	Effective Date:(To be provided by Group Contact)
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.	
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
Signature: Date:	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
	Signature: Date:

**Employees**: Complete and return this form to your employer.

**Employers**: Save time by entering this information online at least 30 days prior to your plan start date. Sign into Online Group Service Center at hellofurther.com. Questions? Call Group Leader Services at 1-888-460-4013.

**Send via secured email only:** further.documents@hellofurther.com

Fax to: 866-231-0214

Mail to: P.O. Box 14836 Lexington, KY 40511