



F.S.A. Enrollment Form

Section 1: Participant Data

Please write legibly using black ink.

Employee Name (First/Last)		Social Security # (REQUIRED)	
Home Address		City	State ZIP Code
Hire Date	Birth Date	Email Address (REQUIRED)	
Employer Name The City of Torrance		Division	

Section 2: Elections

Enter the amount(s) you wish to be withheld for your Annual Election(s). Determine the Per Pay Contribution amount by dividing your Annual Election by the number of pay periods in the Plan Year. Also enter the date of the first paycheck in which a deduction will be withheld.

Plan Year: 1/1/2017 – 12/31/2017	Annual Election	# of Pay Periods	Per Pay Contribution	Eff. Paycheck Date
Healthcare Reimbursement (Annual Limit: \$2,600.00)	\$		\$	
Dependent Care Reimbursement (Annual Limit: \$5,000 per household or \$2,500 if married, filing separately)	\$		\$	

Section 3: Pre-Tax Premiums

I understand that my insurance premiums, for benefits offered by my employer only, will be deducted on a pre-tax basis unless I note otherwise, in writing, to my Human Resources Office.

Section 4: Plan Information

Please read the following regarding this enrollment. If you do not wish to participate in the Flexible Benefit Plan, sign the declination line below. If you wish to enroll in the Flexible Benefit Plan, sign the participation line.

I wish to participate in and deposit funds into a Flexible Spending Account (F.S.A.) as show above. I understand that my election may not be terminated or changed unless I have a qualifying life event as outlined by the IRS. I understand that all claims must be for services provided (not paid) during my coverage period. I further understand that the IRS requires a forfeiture of any remaining balance in my account as of the last day of the run-out period in which I am allowed to submit claims. I understand that, upon termination of my coverage (due to a qualifying life event or termination of employment), I cannot continue to incur additional expenses and that I may only submit claims for services performed prior to my effective termination date. Upon termination of my Healthcare Flexible Spending Account, I may be able to elect COBRA to continue my coverage. In order to receive reimbursement from this account, I must complete and sign a claim form and attach all necessary documentation for myself, my spouse and/or my dependent(s). I understand the plan provisions that have been outlined in the Summary Plan Description available to me from my employer.

In addition, I understand that, if I have a Health Savings Account (H.S.A.), it is my responsibility to review the F.S.A. plan information to ensure my eligibility to participate in both the H.S.A. and the F.S.A. If my plan allows for participation in both, I understand that I can only submit dental and vision expenses to my F.S.A. until my deductible has been met.

PARTICIPATION SIGNATURE: _____ **DATE:** _____

Waiver: *At this time, I wish to waive participation in the Flexible Benefit Plan.*

DECLINATION SIGNATURE: _____ **DATE:** _____

All Enrollment Forms must be submitted to your HR or Benefits Department for processing. **Do not send directly to Sheakley.**

EMPLOYER SIGNATURE: _____ **DATE:** _____