Ohio | Department of Administrative Services

# Flexible Spending Account Enrollment Form

Use this form to enroll in your Flexible Spending Accounts. Please complete all entries on this form. Then print, sign, date this form, and submit the completed form to:

**Postal:**
ConnectYourCare
P.O. Box 622337
Orlando, FL 32862-2337

**Fax:** 866-872-7047

## STEP 1: Personal Information

| | | | |
|---|---|---|---|
| First Name: | | Last Name: | |
| Plan Effective Date: __ __ /__ __ /__ __ __ __ | | Employee ID: | |
| Permanent Address: | | City: | State: / Zip Code: |
| Date of Birth: (Month/Day/Year) __ __ /__ __ /__ __ __ __ | | Email Address: | |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | | Enrollment Status: ☐ New enrollment ☐ Re-enrollment | |

## STEP 2: Health Care Spending Account Elections *(Select Limited Purpose Heath Care Spending Account, which is limited to dental and vision expenses, if you are enrolled or plan to enroll in the HDHP with a Health Savings Account (HSA) plan.)*

☐ Select Health Care Spending Account (HCSA) ☐ Select Limited Purpose Health Care Spending Account (LPSA)

I. Annual Employee Contribution
(Not to Exceed Contribution Maximums*)

*For 2021, Health Care Spending Account contributions are limited to a minimum of $240 and a maximum of $2,500 each year. The limit is per person; a married couple may each contribute up to the specified limit.

## STEP 3: Dependent Care Spending Account Elections

☐ Select Dependent Care Spending Account (DCSA)

I. Annual Employee Contribution
(Not to Exceed Contribution Maximums**)

**Couples who are married and file a joint return, as well as single parents, can contribute a minimum of $240 and up to $5,000 in a Dependent Care Spending Account. Couples who are married and file separately can put a maximum of $2,500 each into a Dependent Care Spending Account.

## STEP 4: Authorization and Certification

I understand that:

- I hereby authorize my employer to reduce my gross salary before Medicare, local, state, and federal income taxes are calculated by the total amount of annual salary deduction indicated above. This election will expire at the end of the calendar year, and I must make a new election each year.
- I am not permitted to change my elections during the calendar year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events and as allowed in the plan documents.
- Funds left in my Dependent Care Spending Account at the close of the calendar year will be forfeited. Funds left in my Health Care Spending Account may be forfeited, per plan rules. See plan documents for more details.
- I certify that only eligible medical, dental, vision and/or dependent care IRS qualified expenses will be requested for reimbursement for myself and/or my IRS eligible dependents incurred during my period of coverage.
- Claims I pay with the card, or request for reimbursement, have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.
- My employer and ConnectYourCare, the contract administrator, will not incur any liability resulting from either my participation in any Spending Account or my failure to sign or accurately complete this Enrollment Form.

I have read and agree to the terms of participation and any applicable certifications in this form and the plan documents. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.

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|---|---|
| Account Holder Signature: | Date: |