WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

FlexShare Benefits

ENROLLMENT FORM

Flexible Spending Accounts

Employer: _____

Name: _____ Email: _____

Phone: (____) _____ Birth Date: _____ Social Security Number: _____

Mailing Address: _____
Street City State Zip

Option I: Medical Spending Account Agreement

☐ **I elect to contribute $_____ (before taxes) per pay period, which is $_____ per plan year,** to fund my account for reimbursement of qualified out-of-pocket medical expenses not covered under my health insurance and any other plans. Maximum Contribution allowed by group _____. (Participants must be Eligible for the Group Health Insurance.)

☐ **I decline to participate in this option for this plan year.**

Option II: Dependent Daycare Spending Account Agreement

☐ **I elect to contribute $_____ (before taxes) per pay period, which is $_____ per plan year,** to fund my account for reimbursement of qualified dependent daycare expenses. (Maximum amount per calendar year is the lesser of, (1) $5,000 for married filing joint or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3) 1/2 of your total annual compensation. If you are single, the maximum amount is $5,000).

☐ **I decline to participate in this option for this plan year.**

Option III: Waiver of Tax Benefits

☐ **I have been given the opportunity to enroll in these tax savings plans and have declined to participate.** I understand that I will lose all tax savings that I may have received as a participant.

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may only change my election in the event of eligible changes in my status. Changes in status may include, but are not limited to marriage, divorce, death, birth, and change of employment. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description.

Employee Signature: _____ **Date** _____

*****Employer Use Only*****

Plan Year: _____ Effective Date: _____ First Payroll Date: _____

FSB 9/14

FlexShare Benefits
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