Version 2023.2

# EMPOWER Flex Plan Enrollment Form

**Employees:** Complete and return this form to your Human Resources representative

**Employers:** Collect the completed forms from employees and follow the instructions at https://info.empowerflex.com/enrollment-instructions/ to submit enrollment

Employer ________________________________ SSN ____________________________________

Employee Name__________________________ Hire Date ______/______/_______

Email ____________________________________________________________________________

Employee ID _____________________________ Date of Birth ______/______/_______

Home Address ____________________________ Work Phone (____) _____-_________

City _____________ State ____ Zip _______ Mobile Phone (____) _____-_________

## Option I: Healthcare Spending Account

☐ **Standard FSA** – *Only available if not enrolled in an HSA Account.*
I want to save on healthcare expenses that my health insurance plan does not cover (copayments, deductibles, costs for dental, orthodontic, vision care, pharmacy, etc.).

☐ **Limited FSA** – *Most often paired with an HSA Account. Only Covers dental and vision expenses.*
I want to save taxes on dental/vision expenses my health insurance plan does not cover.

I elect to contribute $ _______ (before taxes) per Plan Year, which is $ ______ per pay period, to fund my medical reimbursement expense account.

☐ I Decline to participate in Option I this Plan Year.

## Option 2: Dependent Daycare Spending Account

☐ I want to save taxes on daycare expenses. I understand that I may claim up to $5,000 if I am single or married filing jointly, or $2,500 if I am married filing separately.

I elect to contribute $ _______ (before taxes) per Plan Year, which is $ ______ per pay period, to fund my dependent care account.

☐ I Decline to participate in Option II this Plan Year.

*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 if I have a qualifying event as determined by the IRS. 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. Depending on the specifics of my Employer's Plan, any contributions 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 _____/_____/_______