FSA & DCA ENROLLMENT / CHANGE FORM

☐ ENROLLMENT ☐ CHANGE ☐ TERMINATION EMPLOYER: ______________________________

First Name:		Last Name:	
Social Security Number:		Date of Birth:	
Phone Number	☐ Home ☐ Cell	Email:	
Effective Date:		Mailing Address *(please include city, state & zip code)*:	

DEPENDENT INFORMATION:

Last Name	First Name	SS #:	Date of Birth

ELECTION:

	Annual Election	Deduction Per Pay Period	First Payroll Date
Flexible Spending Account*			
Dependent Care Account			

*Note- To participate in the FSA plan, you must be eligible for your company health plan with minimum essential coverage. You also may not *contribute* to a Health Savings Account without notifying Healthy Dollars as your FSA plan may need to be limited to dental and vision expenses only.

Authorization I hereby elect to participate in my employer's FSA and/or DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses.

☐ I **ELECT** to participate in the Healthy Dollars Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars Plan

Employee Signature: ____ Date: ______________

*** **For Accurate Enrollment Please Write Clearly** ***

November 2018