SECTION 125 FLEXIBLE BENEFIT PLAN
ENROLLMENT FORM/DIRECT DEPOSIT AUTHORIZATION

Plan Year Beginning ____/____/____ Ending ____/____/____ Check one: ☐ New Enrollment ☐ Re-enrollment

Employer: _____ Division (if applicable): _____

Employee Name: _____ Soc. Sec. No: _____
Last First MI

Date of Birth: _____ Home Address: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Payroll Frequency: ☐ Weekly (52) ☐ Bi-weekly (26) ☐ Semi-monthly (24) ☐ Monthly (12) ☐ Other _____

Date of Hire: ____/____/____ Effective Date: ____/____/____

Paycheck Deductions Start On: ____/____/____ Number of Deductions in the Plan Year: _____

Benefit Election Authorization or Waiver

Enter the annual amount of your allocation(s) for the Plan Year to the account(s) of your choice and divide by the number of paychecks you receive during the Plan Year to arrive at the amount of your salary reduction each paycheck.

Benefit Elections:	**Annual Amount**		**No. of Paychecks**		**Per Paycheck Reductions**
A. **Health Care Flexible Spending Account (FSA)** (cannot exceed your Plan's maximum)	$_____	÷	_____	=	$_____
B. **Dependent Care Flexible Spending Account (FSA)** (*This amount cannot exceed $5,000 per family per calendar year).	$_____*	÷	_____	=	$_____
Total Authorized Pre-Tax Salary Reductions	$_____				$_____

☐ **Waiver of Participation in Health FSA and Dependent Care FSA.**
After careful consideration, I have chosen not to participate in the FSAs for the current Plan Year.

C. **Premium Payment (Pre-Tax)**
Contributions to the Employer-Sponsored Benefit Plan(s). **PER PAY PERIOD** $_____**

☐ **Waiver of Participation in Pre-tax Premium Payment.**
After careful consideration, I have chosen not to participate in the pre-tax premium portion of the Plan.

**This amount can be automatically increased or decreased during the Plan Year to correspond with increases or decreases in the amount of Employee contributions required by Employer to its benefit plans.

By signing below, I understand that:
- I am authorizing my employer to reduce my compensation by the amount specified.
- I understand that I am not permitted to change my elections during the Plan Year unless the change is on account of and consistent with current recognized IRS regulations and change in status events.
- I also understand that any funds left in my Dependent Care and/ or Health FSAs at the end of the Plan Year will be forfeited in accordance with IRS Regulations.

Employee Signature: **Date:**

Authorization for Direct Deposit of FSA Reimbursements

Complete this section to have your FSA reimbursements deposited directly in your checking or savings account. (Note: please allow up to 30 days for the direct deposit to be operational. After direct deposit has been activated, you will be sent a direct deposit advice showing the amount that has been deposited in your account.) If you are not participating in the FSAs, this section does not apply.

Bank/Institution Name:	Bank/Institution Address: Street City State Zip	
**Routing and Transit Number: Does this match # on voided check? Yes ☐ No ☐	Account Number:	Account Type: ☐ Checking ☐ Savings

**Note:
- If you have designated a Checking Account, please attach a copy of a voided check. Failure to attach a copy of a voided check may result in a delay in entering your enrollment information and/or processing reimbursements.
- If you have designated a Savings Account, please validate the account number as it appears on your statement.
- In order to verify bank routing, the first reimbursement processed after the Direct Deposit Authorization is received may be in the form of a check.
- Your financial institution may have a separate routing number for ACH transactions; please verify the routing number with your financial institution to prevent any delay in receiving reimbursements.

I authorize Infinisource, Inc. to initiate credit/debit entries for reimbursement of my FSA claims to the Bank/Institution listed above into the account specified.

Employee Signature: **Date:**

Infinisource, Inc. has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your FSA coverage.

Fringe Benefits Administration • PO Box 488 • Coldwater, MI 49036-0488
866-370-3040 • Fax: 800-379-5670 • www.benefitsolved.com • E-mail: fsa@benefitsolved.com

Infinisource COBRA Compliance Systems Inc.

White – Infinisource **Yellow – Employer** **Pink - Employee**