# EMPLOYEE ENROLLMENT FORM
## Flexible Spending Account (FSA)

**Instructions:** Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected. **Return the completed and signed form to your employer for processing**.
**For Employer to complete where applicable:**

| | | | |
|---|---|---|---|
| Client/Company Name: | | TASC ID: | |
| Employer Class: | | Employer Division: | |
| Participant Plan Effective Date: | | First Payroll Date: | |

## INDIVIDUAL/PARTICIPANT INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| First Name: | | MI: | | Last Name: | | |
| TASC ID (if known): | | Email Address: | | | | |
| Primary Phone: | | Mobile Phone: | | | | |
| Primary Address: | Address Line 1: | | | | Apt: | |
| | Address Line 2: | | | | | |
| | City: | | | | | |
| | State: | | ZIP/Postal Code: | | +4 | |
| Date of Birth: | | Hire Date: | | Payroll Frequency: | | |

## ANNUAL ELECTIONS

***Prior to completing your election amounts below, please refer to the instructions on page 2.***

| I select the following benefits and amount(s) to be deducted pretax: | | Employee Annual Salary Reduction Election Amount | EMPLOYER Annual Contribution | Maximum Employee Annual Election |
|---|---|---|---|---|
| ☐ | **Healthcare FSA** | $ | $ | $ |
| ☐ | **Limited Purpose Healthcare FSA** | $ | $ | $ |
| ☐ | **Dependent Care FSA (Daycare Expenses)** | $ | $ | $ |
| ☐ | **Healthcare Premium (NESP) Reimbursement Account** | $ | $ | $ |

## TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.
**To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):**

| | | |
|---|---|---|
| 1 | **Spouse or Dependent Name (First, MI, Last):** **(No fee)** | |
| 2 | **Dependent Name (First, MI, Last):** **(Additional fee may apply)** | |
| 3 | **Dependent Name (First, MI, Last):** **(Additional fee may apply)** | |

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

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## Flexible Spending Account (FSA)

### AUTHORIZATION

I certify the above information to be true to the best of my knowledge. I further certify that I can claim a tax exemption for the dependents whose expenses I claim from my Dependent Care FSA, and that the expenses I claim from my Healthcare FSA will not have been incurred by a spouse who is enrolled in a Health Savings Account. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my FSA(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my employer and/or payroll processor. I understand additional TASC Cards issued to my spouse or dependent(s) will provide the named individual(s) with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual(s) and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my employer.

Signature: _____ Date: _____

### ELECTION INSTRUCTIONS

**Instructions for entering elections under each applicable benefit account type:**

1. **Healthcare FSA Election:** The amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental, orthodontic, and eye care expenses. Participants may elect a maximum based on the current IRS limits. Your employer's plan maximum may be less than the IRS maximum. Review your Summary Plan Description (SPD) for your specific plan maximum. Your election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement of eligible expenses on the first day of the plan year.
2. **Limited Purpose Healthcare FSA Election:** Amount you expect to pay out-of-pocket for dental and vision expenses throughout the plan year. Your total election amount is available on the first day of the plan year as expenses are incurred. Refer to your SPD for your specific plan maximum.
3. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible dependent care expenses for the Plan Year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single. Plan funds are available as they are contributed.
4. **Healthcare Premium (NESP) Election:** The total annual out-of-pocket cost for privately purchased (individual) insurance *premiums* such as health, disability, and cancer insurance. Other medical expenses are not eligible under the NESP Plan. Examples of insurance premiums NOT eligible are employer-sponsored group insurance (premiums deducted from your paycheck or your spouse's paycheck), life insurance, long-term care insurance, and premiums for coverage under the federal exchange "Marketplace" program. Please note, when disability premiums are pre-taxed, the benefits received are taxable. NESP is not subject to contribution limits unless otherwise set by your employer but is subject to the 'Use it or Lose it' rule in which unused funds are forfeited at year-end. Plan funds are available as they are contributed.

**IMPORTANT NOTE:**
How Cafeteria Plans affect Social Security Benefits: Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs available under an FSA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.

**For enrollment assistance: call toll-free 800-422-4661**
**Have your enrollment form, employer name, and the TASC ID ready.**
Find all IRS limits on our website: www.tasconline.com/resources/benefit-limits