EMPLOYEE ENROLLMENT FORM

SIMPLE Flexible Spending Account (FSA)

Matching Employer Contribution

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.

EMPLOYER INFORMATION

Client/Company Name:		Client/Employer 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[1]:			
Primary Phone #:		Mobile Phone #[1]:			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	
Date of Birth:		Hire Date:		Payroll Frequency:	

All fields are required for account setup. Information is confidential and is not used for marketing purposes.

[1]*Please provide this information if available (not required).*

ANNUAL EMPLOYER CONTRIBUTION

Your employer provides an annual contriution to your FSA plan based on the lessor amount of 6% of your compensation for the plan year or 2 times your elected salary reductions. Determine this amount in A–D.

A	Your salary/compensation for the plan year =	$
B	6% of salary (multiply the amount in A x 6%) =	$
C	2x Employee total qualified salary reductions (column F total) and multiply x 2 =	$
D	Enter the lessor amount shown in B and C above = This is your **Annual Employer Contribution**	**$**

EMPLOYEE SALARY REDUCTIONS AND DISTRIBUTION OF EMPLOYER CONTRIBUTIONS

Designate below your salary reduction election amount(s) for the plan year in column F. Distribute all of the Annual Employer Contribution amount (from Line D above) among the qualified benefits below (list in column E).

I select the following benefits and amount(s) to be deducted pretax: Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits/		**E) Employer Contribution**	**F) Employee Salary Reduction**	**G) Total Benefit Election**
☐	**Healthcare FSA** ($500 employer max)	$	$	$
☐	**Limited Purpose Healthcare FSA** ($500 employer max)	$	$	$
☐	**Dependent Care FSA**	$	$	$
☐	**Healthcare Premium (NESP) Reimbursement Account**	$	$	$
Important: Complete the required Authorization Signature on page 2 for the benefits elected above. See your employer to complete the applicable enrollment forms for the additional employer sponsored qualified benefits you elect below.				
☐	**Other Qualified Benefits** (group health premiums, HSA, etc; list each benefit:) _____	$	$	N/A
	TOTALS (column E total must equal the Annual Employer Contribution in D above)	$	$	N/A

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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)	

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(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 payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual 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

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 expenses, eye care, and other eligible healthcare expenses. The maximum you may elect is the lessor of the current IRS limits or your employer's plan maximum. Review your Summary Plan Description (SPD) or check with your employer for your plan's maximum annual amount. Your total annual election amount is available for reimbursement on the first day of the plan year as eligible expenses are incurred.
2. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the plan year. Your annual contribution must be within the maximum allowable amount under IRS regulations for a family or for married individuals filing single. Plan funds are available as they are contributed.
3. **Healthcare Premium (NESP) Reimbursement Account Election:** The total annual out-of-pocket cost for privately purchased (individual) insurance ***premiums*** such as health, disability, and cancer insurance. 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. NESP Account funds are available as they are contributed.

For enrollment assistance: call toll-free 800-422-4661
Have your enrollment form, employer name, and the Client ID# ready.

Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits/