Complete this form and return it to your benefits representative.

Employee Information

Employer Name ______________________________

Employee Name ______________________ Account Number or SSN ______________________

Street Address ______________________ Daytime Phone Number ______________________

City ______________________ State __________ ZIP Code __________

Date of Birth __________ Date of Hire __________ Gender ☐ Male ☐ Female

Add your email address to receive messages about your account: ______________________

Elections

Health Flexible Spending Account

The maximum amount you may elect is $2550.00.

☐ I elect to participate $__________ per pay period x _____ remaining pay periods = $__________ Plan Year Total

☐ I elect to waive coverage

Dependent Care Flexible Spending Account*

Annual maximum allowable is:

- $5,000 if married filing jointly or single
- $2,500 if married filing separately

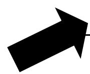
☐ I elect to participate $__________ per pay period x _____ remaining pay periods = $__________ Plan Year Total

☐ I elect to waive coverage

Find additional FSA details at www.conexis.com/myfsa.

Employee Certification

- I understand I may elect coverage under any or all of the above components;
- I understand completion of this form does not guarantee medical insurance coverage will be initiated and, if applicable, an application for medical insurance must also be completed;
- I understand the terms of eligibility of this plan do not override the terms of eligibility of each of the available benefit plan options;
- I understand my election is irrevocable for the plan year unless I have a change in status or other qualifying event as defined in the plan and IRS regulations, and the requested change is on account of and consistent with the event;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand participation in this plan reduces my social security withholdings and could reduce my social security benefits;
- I certify I have read and agree to the terms above.



Employee Signature ______________________ Date ______________

For Employer Use Only					
Company Name	Division	Effective Date	Pay Cycle	Entered in Payroll	Initial

*It is important to note the general annual maximum is set at $5,000.00, your maximum annual contribution amount may not exceed the earned income limitation. If you are single, the earned income limitation is your salary (excluding your contributions to the dependent care FSA plan). If you are married, the earned income limitation is the lesser of your salary (excluding your contributions to the dependent care FSA plan) or your spouse's salary.

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