City of Fishers
DEBIT CARD FLEXIBLE SPENDING ACCOUNT
ELECTION FORM

IDENTIFYING INFORMATION

NAME (please print): _____ **First Pay Date** (First Time Enrollees Only)**:** _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____ **DATE OF HIRE:** _____

FSA ENROLLMENT EFFECTIVE DATE: _____

ADDRESS: _____

P.O. Box and/or Street **City** **State** **Zip**

EMAIL ADDRESS: _____

REQUESTING ADDITIONAL CARDS - *I would like to request additional cards for the following individuals. I certify they are at least 18 years of age and are indicated as a dependent on my current IRS tax filing.*

Dependent Name: _____ Dependent DOB: _____ Dependent SSN: _____
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ELECTION OF COVERAGE

I, an employee of City of Fishers, have been informed of all benefits available to me through my Employer. I have also been informed that through my benefit election I will be deemed to have elected to make the benefit contributions with pre-tax dollars within the guidelines of the Revenue Act of 1978. I understand that the total amount of funds I elect to have set aside for Dependent Care Expenses on a pre-tax basis will reduce my pay in that amount. **I understand that the elections I make will remain in effect for the plan year from 1/1/2019 through 12/31/2019.**

Please Note: The maximum contribution for Dependent Day Care is $5,000.

Benefits Available Pre-Tax	Amount Deducted Per Pay		# of Pays Annually		Total Annual Deduction
_____ Dependent Care Expense	_____	X	_____	=	_____

I understand that:

* I cannot change this election during the plan year unless I have a change in family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse).
* Any amounts remaining in my reimbursement accounts at the end of the year, not to exceed $500, may be used in the subsequent plan year.
* My Social Security benefits may be reduced by this election.
* This election replaces any previous elections and will terminate on the earlier of: (1) the end of the plan year, (2) when I am no longer being paid compensation in an amount at least equal to my total salary reduction, (3) termination of the plan.
* My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

SIGNATURE

Date: _____ Employee Signature: _____

DECLINATION OF COVERAGE

☐ Checking this box and signing/dating this form will verify that I decline the benefits explained to me this day. I understand that I will not be eligible to participate again until the following "plan year" anniversary date.

Date: _____ Employee Signature: _____