Flexible Benefits Plan - New Hire Enrollment Form

I. Personal Information

T# _____

Your Name _____ _____ _____
(Last) (First) (MI)

Address _____ **City** _____ **State** _____ **Zip** _____

Date of Birth _____/_____/_____ **Hire Date** _____/_____/_____

II. Election Information **(Please check the appropriate box to indicate if you wish to enroll, and sign below.)**

☐ Yes, I wish to participate in the **Heath Care and/or Dependent Care FSA** plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ Yes, I wish to participate in the **Limited Purpose and/or Dependent Care FSA** plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis. **Only available if you are enrolled in the CDHP/HSA medical plan.**

	PER PAY PERIOD PERIOD AMOUNT		# OF PAY PERIODS REMAINING		TOTAL PLAN YEAR AMOUNT
Health Care Flexible Spending Account (FSA) • If you are enrolled in a Health Savings Account, you cannot enroll in a Health Care FSA. • Annual Maximum Contribution $3,300	$_____	X	_____	=	$_____
Limited Purpose Flexible Spending Account • Only available if you are enrolled in **the CDHP/HSA medical plan**. • Annual Maximum Contribution $3,300	$_____	X	_____	=	$_____
Dependent Day Care Flexible Spending Account • If married, this amount is less than my spouse's earned income. Please refer to the IRS guidelines for further information. • Married, Filing Separately Maximum $2,500 • Married, Filing Jointly Maximum $5,000 • Head of Household Maximum $5,000	$_____	X	_____	=	$_____

I understand that:

- I understand this is not an application for insurance. To enroll or change my medical, dental or vision insurance, I must complete the proper forms.
- I hereby authorize TSU to reduce my gross salary before federal and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect for the plan year unless I file an approved family status change.
- I understand that any amount remaining in my Dependent Care Spending account that is not used during the plan year will be forfeited, since it cannot be carried to the next plan year. I also understand that any funds in excess of $640 remaining in either the Health Care Flexible Spending account or Limited Purpose Flexible Spending account will be forfeited. Funds of $640 or less will carry over into the following plan year.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.

Employee Signature _____ ***Date*** _____ ***Rev.1/2025***