STERLING ADMINISTRATION

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WE MAKE THE COMPLEX SIMPLE

HEALTHCARE FSA ENROLLMENT FORM

EMPLOYEE INFORMATION *(PLEASE PRINT CLEARLY)*

Employee's First Name: _____ M.I. ____ Last Name: _____

Social Security #: _____ Date of Birth: _____ ☐ Male ☐ Female

Employee's Home Address: _____ City: _____ State: _____ Zip: _____

Employee's Home Phone: _____ Email: _____ Employer Name: _____

Flexible Spending	Annual Election _____	Per Pay Period Contribution _____	Payroll Schedule _____
Limited Purpose or Post-Deductible FSA	Annual Election _____	Per Pay Period Contribution _____	Payroll Schedule _____
Dependent Care	Annual Election _____	Per Pay Period Contribution _____	Payroll Schedule _____
Transit Plan	Annual Election _____	Per Pay Period Contribution _____	Payroll Schedule _____
Parking Plan	Annual Election _____	Per Pay Period Contribution _____	Payroll Schedule _____

☐ Please check this box if you also have a health savings account (HSA)

DEPENDENT INFORMATION

FIRST NAME	LAST NAME	SSN #	BIRTH DATE	RELATIONSHIP (SPOUSE or DEPENDENT)	GENDER (M or F)	STUDENT (Y or N)

I acknowledge and agree to these IRS required conditions for reimbursement. The IRS regulation states four conditions. 1) Any expenses you incur must be within the plan year; 2) Expenses you incur may not be reimbursed by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your election during the plan year unless there is a specific change of status and your employer allows such changes.

Signature: _____ Date: _____

EMPLOYEE INFORMATION *(EMPLOYER TO COMPLETE THIS SECTION)*

Plan Effective Date: _____
Month Date Year First Pay Period Date Effective