WageWorks®

Pennsylvania State System of Higher Education

Plan Year January 1, 2013 - December 31, 2013

PASSHE
Pennsylvania State System of Higher Education

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start or continue a tax-free Medical Reimbursement and/or Dependent Care Reimbursement FSA.

Name (Please Print) Last	First	MI	Employee ID #
Home Address Street	City	State	Zip
Daytime Phone ( )	Home Phone ( )	Date of Hire	Effective Date
E-mail Address	ENROLLMENT STATUS: ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ NEW HIRE		

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
Complete the worksheets provided in your 2013 Flexible Spending Accounts Reference Guide before deciding on the amount.
If you have questions, consult your 2013 Flexible Spending Accounts Reference Guide, or call WageWorks Customer Service at 1-877-924-3967.

In Box #1, indicate the dollar amount you elect to contribute for the January 1, 2013, through December 31, 2013, plan period.
In Box #2, indicate the number of regular payroll checks you expect to receive during the January 1, 2013, through December 31, 2013, plan period.
In Box #3, indicate the deduction amount per paycheck. (**Note:** If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly due to rounding).

MEDICAL REIMBURSEMENT FLEXIBLE SPENDING ACCOUNT

Use your Medical Reimbursement FSA for eligible uninsured, out-of-pocket medical expenses incurred by you, your family members or both. Maximum contribution is $2,500 for the plan period.

Box #1
Total plan period dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected (20 or 26) ÷ _____

Box #3
Reduction per regular paycheck = _____

DEPENDENT CARE REIMBURSEMENT FLEXIBLE SPENDING ACCOUNT

Use your Dependent Care FSA for eligible dependent care expenses such as daycare, after school care and elder care.

TAX FILING STATUS– PLEASE CHECK ONE:

☐ Married, filing separately [maximum - $2,500] ☐ Married, filing jointly [maximum - $5,000] ☐ Single, head of household [maximum - $5,000]

Box #1
Total plan period dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected (20 or 26) ÷ _____

Box #3
Reduction per regular paycheck = _____

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal, state and Social Security taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand the contribution to my Social Security account will be reduced since contributions will be based on my income after deductions.
- I understand that any amount remaining in any FSA that is not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax returns.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change in Status before the end of the plan period.
- I understand and agree that my employer and WageWorks the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate in the plan during the upcoming plan year.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE SIGNED

SUBMIT YOUR COMPLETED FORM BY NOVEMBER 16, 2012, TO HUMAN RESOURCES.