



# Flexible Spending Account Enrollment Form

Complete this form to enroll in a flexible spending account. Your employer will withhold funds from your paycheck for certain medical and dependent care expenses. These funds are taken out of your paycheck before taxes.

Plan Year \_\_\_\_\_ to \_\_\_\_\_  
(MM/YY) (MM/YY) Employer \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Hire \_\_\_\_\_ ZIP \_\_\_\_\_  
(MM/DD/YY)

**Waiver of Participation.** I choose not to participate in the Flexible Spending Account at this time. I understand that I will not have another opportunity to enroll during the plan year unless I experience a qualifying event.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

NOTE: The worksheet on the back of this page will assist you in determining how much of your salary you may want to place into your Flexible Spending Account(s).

- 1. **Medical Expense Reimbursement Account** \$ \_\_\_\_\_ /year which is \$ \_\_\_\_\_ /paycheck
- 2. **Dependent Care (Daycare) Expense Reimbursement Account** \$ \_\_\_\_\_ /year which is \$ \_\_\_\_\_ /paycheck
- 3. **Health Premium / Medical Insurance Reimbursement Account** \$ \_\_\_\_\_ /year which is \$ \_\_\_\_\_ /paycheck

I authorize my employer to withhold the above deductions from my paycheck on a pretax basis. I understand that the benefit options I have elected will remain in force throughout the plan year, unless I have a qualifying event.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Direct Deposit** I hereby authorize Avera Health Plans to initiate direct deposits and if necessary, adjustments for any deposits made in error, to the account indicated:  Savings (**Attach a deposit slip**)  Checking (**Attach a voided check**)

Account Number \_\_\_\_\_ Transit ABA Routing Number \_\_\_\_\_

Bank Name \_\_\_\_\_ Bank Location \_\_\_\_\_ Phone \_\_\_\_\_

If taking advantage of direct deposit, do you want your Flex Explanation of Benefits emailed to you?  
 No  Yes If yes, your email address: \_\_\_\_\_

After you have completed the form, attach your voided check or deposit slip and give to your employer.

**FOR EMPLOYER USE ONLY**

Employer Name \_\_\_\_\_ Payroll Frequency \_\_\_\_\_  
Effective Date \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Qualifying Event \_\_\_\_\_ Effective Date of Qualifying Event \_\_\_\_\_

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# Flex Spending Account Worksheet

## Medical Expense Reimbursement Account

Complete this worksheet to determine how much of your salary you should place into your Medical Expense Savings Account.

Be as accurate as possible when recording last year's expenses and be conservative when estimating next year's expenses.

Any money you put into the program must be used exclusively for eligible unreimbursed medical expenses and you forfeit any money remaining in this program at the end of the year.

If you are covered by a dental plan, be sure to include only additional uninsured amounts beyond deductibles and coinsurance in Section 3.

If you don't have dental insurance, most medically necessary expenses are eligible for reimbursement.

## Dependent Care Reimbursement Account

IRS regulations limit the amount you can contribute to a Dependent Care Reimbursement Account to \$5,000 for a married parent filing jointly or a head of household filer, and \$2,500 for a married parent filing separately.

The cost of a kindergarten program does not qualify if the program's purpose is primarily educational. Overnight camp expenses are not qualified expenses.

Only expenses necessary to provide care for a dependent while you are working are eligible for reimbursement.

Estimate expenses as accurately as possible. Any money left in your account can not be returned to you.

	Actual expenses last year	Expected expenses for coming year
<b>SECTION 1: Deductibles and Coinsurance</b>		
How much do you and your spouse pay each year to fulfill medical and dental insurance deductibles?	_____	_____
How much do you and your spouse pay each year to fulfill medical and dental insurance coinsurance requirements?	_____	_____
<b>Total annual cost for Section 1</b>	_____	_____
<b>SECTION 2: Other unreimbursed medical expenses</b>		
Routine exams	_____	_____
Prescription drugs	_____	_____
Vision care	_____	_____
Equipment/other expenses for the disabled	_____	_____
Treatment of mental/nervous conditions	_____	_____
Treatment of alcoholism or drug dependency	_____	_____
X-rays	_____	_____
Other uninsured medical expenses	_____	_____
<b>Total annual cost for Section 2</b>	_____	_____
<b>SECTION 3: Other unreimbursed dental expenses</b>		
Exams and cleaning	_____	_____
Braces and retainers (only if medically necessary)	_____	_____
Fillings, crowns, bridges	_____	_____
X-rays	_____	_____
Dentures	_____	_____
Other uninsured dental expenses	_____	_____
<b>Total annual cost for Section 3</b>	_____	_____
<b>Grand totals (last year and upcoming year) Section 1 + Section 2 + Section 3</b>		
_____	_____	_____
<b>SECTION 4: Dependent care expenses</b>		
Day care center	_____	_____
Nursery/preschool	_____	_____
Before/after school expenses	_____	_____
Dependent care expenses	_____	_____
Other dependent care expenses	_____	_____
<b>Total annual cost for Section 4</b>	_____	_____