



# FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

## EMPLOYEE INFORMATION

|                 |                                     |                            |                        |               |
|-----------------|-------------------------------------|----------------------------|------------------------|---------------|
| Last Name       | First Name                          | M.I.                       | Social Security Number | Date of Birth |
| Mailing Address | City                                | State                      | Zip                    | Email Address |
| MESA Hire Date  | Temporary Hire Date (if applicable) | Effective Date of Coverage |                        |               |

## DEPENDENT INFORMATION

Must reside in Employee's household and must be included as a dependent on tax return

| Name (Last, First, M.I.) | Relationship   | Social Security Number | Date of Birth |
|--------------------------|--|------------------------|---------------|
|                          | <input type="checkbox"/> Spouse <input type="checkbox"/> Child |                        |               |
|                          | Child  |                        |               |
|                          | Child  |                        |               |
|                          | Child  |                        |               |
|                          | Child  |                        |               |

## ELECTION INFORMATION

My employer and I agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected under the Flexible Spending Account, and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each is set forth below.

|  |                   |  |               |  |
|--|-------------------|--|---------------|--|
| <input type="checkbox"/> Unreimbursed Medical (\$2550 annual max)                      | Per Pay Deduction |  | Annual Pledge |  |
| <input type="checkbox"/> Dependent Care (\$2500 – single / \$5000 – family annual max) | Per Pay Deduction |  | Annual Pledge |  |
| <input type="checkbox"/> I do not want to participate in MESA's FSA this year          |                   |  |               |  |

## REIMBURSEMENT METHOD (select one)

|  |
|--|
| <input type="checkbox"/> Flex Debit Card   |
| <input type="checkbox"/> I would like reimbursements made automatically from my account<br><i>You may not elect this option if you or any of your dependents have a secondary carrier outside of MESA.</i> |
| <input type="checkbox"/> I will submit receipts for the bills I would like reimbursed from my account  |

## ACCEPTANCE OF PARTICIPATION

The terms of the Flexible Spending Accounts under the section 125 Cafeteria Plan have been explained to me and I have read the descriptive material. I understand my options with regards to elections made under it. I hereby elect the benefits as indicated above and agree to have the pre-tax benefits purchased as an employer contribution on my behalf. I understand that by signing and submitting this enrollment form, that the benefits above will remain in effect for the entire plan year and that this election cannot be revoked or changed during the plan year, unless there is a change in family status (i.e., marriage, divorce, death of a spouse, or birth or adoption of child and termination of employment of a spouse).

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

## DECLINING PARTICIPATION

This plan has been explained to me and I choose not to participate this year.

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

### To be completed by MESA

Frequency of Pay:  Weekly  Bi-Weekly  Semi-Monthly  Monthly

First Pay Date of Deductions: \_\_\_\_/\_\_\_\_/\_\_\_\_  5% Owner  Key Employee  Highly Compensated Employee