ebms

*The Benefit of Balance*

*Employee Benefit Management Services, Inc*

**CITY OF YAKIMA FSA Enrollment Form**

P.O. Box 21367 Billings, MT 59104-1367 Phone: 866.857.8182 Fax: 877.236.9868 Email:flex@ebms.com

**SECTION A: Demographic Information**

| | | | |
|---|---|---|---|
| Employees Last Name | First Name | Middle Name | |
| Social Security Number | Date of Birth | Phone Number | Marital Status Single Married |
| Current Mailing Address Street | City | State | Zip |
| Date of Hire | Employee Number | | |

**SECTION B: Elections - Please select one: Enroll or Decline**

◯ **ENROLL**

**Note:** If you or your spouse participate or plan to participate in a Health Savings Account, you are ineligible to participate in a Health FSA.

I elect to receive the following coverage(s) under the Cafeteria Plan:

| | Annual Election* | FOR HR USE ONLY # of deductions | FOR HR USE ONLY Monthly deduction |
|---|---|---|---|
| ☐ Health Flexible Spending Account | _____ | _____ | _____ |
| ☐ Dependent Care Assistance Plan | _____ | _____ | _____ |

***Annual election will be distributed equally over the remaining pay periods of the calendar year.**

**Note:** There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask your Plan Administrator if you have any questions. With regard to my salary reduction agreement and my election of benefits, I understand that:

- Funds contributed to the Flexible Spending Account must be used in the elected plan year..
- I may not change the election during the Plan Year unless there is a change in my family status (e.g. termination of employment or change to part time status by either myself or my spouse, marriage, divorce, death of my spouse or child, adoption or birth of my child) if the change is allowed by my Flex Plan Document.
- My employer and I agree that my compensation will be reduced by the amounts set forth above for each pay period during the Plan Year (or during such portion of the year as remains after the date of this agreement).
- The Plan Administrator is authorized to adjust the amount of my salary reduction and benefits if it is necessary to satisfy certain provision of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My election of salary reduction and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year.
- My Social Security benefits may be reduced as a result of my election.
- I understand and agree that this agreement is: 1. Subject to the terms of the company's Cafeteria Plan, Health Flexible Spending Account, and/or Dependent Care Assistance Plan as amended from time to time; 2. Shall be governed by and construed in accordance with applicable laws; 3. Shall take effect under applicable laws; and 4. Revokes any prior election and compensation reduction agreement relating to such plan(s).

◯ **DECLINE**

The benefits of this plan have been thoroughly explained to me and I decline to participate. I understand that if I elect not to participate, I cannot enter the program until next year unless I experience a status change in accordance with Internal Revenue Code Section 125 and submit the change within 30 days of the status change.

**Employee Signature**_____ **Date** _____

***Please return this completed form to your employer.***