inspira™ FINANCIAL

Reimbursement Accounts Enrollment Form

HQ Benefits Use Only

Payroll ID Number _____

Re-enrollment ☐ New ☐ Change ☐

Effective Date _____

1st Payroll Deduction Date _____

☐ ☐ ☐ ☐ ☐

Effective Date _____

A. Personal Information (Be sure to print clearly and complete each section.)

Employer Name			
Employee First Name	MI	Last Name	SAP #
Employee Street Address			
City	State	ZIP Code	
Employee email		Date of Hire (MM/DD/YYYY)	

B. Election Information (Check the box to indicate if you wish to enroll or not.)

☐ **Yes, I wish to participate in the Benefit Choice(s) offered below. I authorize payroll deductions on a pre-tax basis in the amount(s) listed below. I know this election is for the entire Plan year.**

☐

Completed by EMPLOYEE — To be completed by HQ BENEFITS

BENEFIT CHOICES	ANNUAL AMOUNT		NUMBER OF PAY PERIODS		BI-WEEKLY DEDUCTION
Health Care Flexible Spending Account (FSA) • Your employer's Plan sets the minimum and maximum contribution amounts, up to the Internal Revenue Service (IRS) limit.	$_____._____ MIN $200 - MAX $3,400	/	_____ (remaining in the year)	=	$_____._____
Dependent Care Flexible Spending Account (DCFSA) • Your employer's Plan sets the minimum contribution amou. The maximum contribution amount is $5,000, as set by the IRS. • If you're married and your spouse is disabled, a full-time student earns less than you or if you file separate tax returns, your contribution limit may be lower. Review your Plan for more information. You can also refer to IRS Publication 503 at **irs.gov**.	$_____._____ MIN $200 - MAX $7,500	/	_____	=	$_____._____

By signing this, you agree to the following statements:

- I know this election is for the entire Plan year.
- I know that the only way to change my election during the Plan year is if I have a change in status or become ineligible to participate. The new election must be consistent with my change in status. I must apply for it within 30 calendar days of the change or as allowed by the Plan, and my employer must approve it.
- My employer will change or cancel this election, if needed, to comply with the Internal Revenue Code.
- If I elect the DCFSA, I understand that the IRS sets the maximum salary contribution allowed. My tax filing status and if married, my spouse's income limits the amount. I know I must file IRS Form 2441 with my income tax return.
- I know that I will forfeit any amounts left in my account at the end of the Plan year, unless my Plan allows carryover for the FSA. This is defined in the Plan.
- I know that funds can't be transferred between these accounts.
- I know that for FSA and/or DCFSA I need to complete and submit a new Enrollment Form for each Plan year. If I don't complete and return an Enrollment Form during Open Enrollment, I won't be able to participate in these accounts for that Plan year.
- If I elect the FSA and/or DCFSA, I understand that when I elect pre-tax salary deductions, Social Security and Medicare taxes are not withheld from those amounts.
- If I elect the FSA and/or DCFSA, I understand that I cannot claim the amount of salary deductions on my or my spouse's income tax returns.
- I know that if my employment ends, I can only claim medical expenses incurred through my period of coverage. This is defined in the Plan.
- I know that I have to include documentation with each claim to show that the expense is eligible for reimbursement.
- If I use my Inspira Financial Debit Card, I agree to use the card for eligible expenses only and to keep all itemized receipts and statements. I agree to read and adhere to the cardholder statement I receive with the card. I know the card may be turned off if I don't comply with the card rules or if my employment ends and I no longer have this account.
- When I use my Inspira Financial Debit Card or submit a claim, I haven't been reimbursed and I won't seek reimbursement elsewhere.

C. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ **I authorize Inspira Financial to initiate a credit and/or debit entry to my account for my Inspira reimbursements.**
This agreement is to remain in full effect until written notification is supplied by me to Inspira terminating this agreement.
A "VOIDED" CHECK OR SAVINGS DEPOSIT SLIP MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

Employee Signature _____ **Date** _____