BPAS

Enrollment

Submit this completed form to your Human Resources, Personnel, or Benefits Administration Department.
Need help? Call us toll free at 1-866-401-5272

EMPLOYER NAME

PLAN YEAR (MM/DD/YYYY – MM/DD/YYYY)

1. EMPLOYEE/PARTICIPANT INFORMATION

LAST NAME | FIRST NAME | MI | Participant Social Security No. (SSN) or Secondary ID # **(REQUIRED)**

MAILING ADDRESS ☐ Check here if new address | CITY | STATE | ZIP

DATE OF BIRTH | E-MAIL ADDRESS (home or personal recommended) ☐ Check here if new email address | AREA CODE/PHONE NUMBER

☐ MALE ☐ FEMALE
☐ MARRIED ☐ UNMARRIED

DATE OF HIRE | PLAN EFFECTIVE DATE

2. SPOUSE/DEPENDENT INFORMATION

NAME	SSN	Date of Birth	Relationship	Full-time Student? Y/N

3. FLEXIBLE SPENDING ACCOUNT FSA

☐ NEW ENROLLMENT

☐ CHANGE (PLEASE CHECK REASON FOR CHANGE BELOW):
☐ MARRIAGE ☐ DIVORCE ☐ BIRTH OR ADOPTION ☐ DEATH
☐ CHANGE IN SPOUSE'S EMPLOYMENT ☐ OTHER: _____

Health FSA	Dependent Care FSA
You may set aside tax-free dollars to pay for qualified medical, dental, and vision expenses up to the annual maximum set by the IRS. Visit IRS.gov or see your HR department for current limits. ☐ I wish to participate in the health FSA. Please deduct $_____ each pay period. ☐ I decline to participate in the Health FSA.	You may set aside tax-free dollars to pay for qualified dependent care expenses. The maximum annual contribution is $5,000. ☐ I wish to participate in the dependent care FSA. Please deduct $_____each pay period. ☐ I decline to participate in the Dependent Care FSA.

4. DIRECT DEPOSIT AUTHORIZATION

Exact Name on Account	
Bank Name	
Transit Routing Number	
Account Number	
Account Type	☐ Checking Account ☐ Savings Account

5. PARTICIPANT SIGNATURE

I authorize BPAS to initiate credit/debit entries at the Depository named below. This authority will remain in full force and effect until BPAS has received written notification from the account signatory in such time and manner as to afford BPAS and Depository a reasonable time to act upon it.

I agree to be bound by all the terms, conditions and limitations of the Plan and any and all separate plans, contracts and documents made a part thereof. I agree to have my gross salary reduced by the amount of the cost of benefits selected and understand that this amount will not be subject to Social Security or federal income tax withholding, which may result in a reduction of future Social Security benefits to which I may be entitled. I understand that my unused balance of the reimbursement accounts, if any, at the earlier of the end of the Plan Year or my date of termination may be forfeited back to my employer.

Debit Card Agreement: By using the debit card issued to me and/or my dependents, I hereby certify that the card will only be used for eligible medical expenses. I also certify that expenses paid with the card will not be reimbursed from another source, and that I will not seek reimbursement from any other plan covering health benefits. I understand and agree that if the card is used for ineligible expenses, I will be required to pay those amounts back to the plan. I also understand and agree that repeated misuse of the card may result in the card being deactivated. I further understand and agree that unsubstantiated expenses, which are not reimbursed to the plan, may be included on my W-2 as taxable income.

X_____

Participant Signature | *Date*