Flexible Spending Account (FSA) Employee Enrollment Form
Plan Year: July 1, 2025 – June 30, 2026

HealthEquity
Building Health Savings

Please return FSA Enrollment Form back to Jeanne Portalski / 12900 Frazho Road, Door 16, Warren, MI 48089

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Annual Elections

	Election Amount Per Pay Period	Number of Pay Periods Remaining in Plan Year		Your Annual Election Amount
Health Care Flexible Spending Account **$3,300 Annual Maximum**	$	X	=	$
Limited Purpose Health Care Flexible Spending Account **$3,300 Annual Maximum**	$	X	=	$
Dependent Care Flexible Spending Account **$5,000 Annual Maximum**	$	X	=	$
Contribution Per Pay Period x Number of Pay Periods = Your Annual Election Amount				

Signature

☐ I decline to participate in the FSA plan.

Print Name	Signature	Date

UNDERSTANDING OF AGREEMENTS

I have received the printed material explaining the Plan and my options under the Plan, and, I understand that by signing this form, I am making an election which may not be changed for this Plan year other than as permitted by law and the Plan.

I understand that by electing to be covered under the applicable Employer's insurance plan(s), my portion of the premium is automatically reduced from pre-tax wages under the Flexible Compensation Plan, if applicable. Further, I understand that if I do not incur expenses this Plan Year in the amount which I have elected for each benefit, the Plan has for 2025-2026 Plan Year to allow $660.00 carryover rule.

I authorize the reduction of these amounts from my paychecks and acknowledge that these amounts are to be credited to my Flexible Compensation accounts. I authorize the Administrator to draw upon my accounts to reimburse me for eligible expenses incurred by me during the Plan Year. I understand that requests for reimbursement from the reimbursement plan(s) will only be processed if I comply with the terms and conditions of the applicable plan. I also understand that the Plan Administrator and Third Party Claims Administrator may establish rules and procedures from time to time, which also govern processing reimbursement requests. In addition, the Plan Administrator may establish rules and procedures regarding payment of remaining reimbursement contributions upon termination of employment in accordance with the applicable Flexible Benefit Plan Document(s). The Employer and Plan Administrator may take appropriate legal action to assure that reimbursements are made in accordance with the terms and conditions of the reimbursement plan(s).

DEPENDENT CARE

I understand that, for this Plan Year, I may be reimbursed for dependent care expenses up to the maximum of (1) Five Thousand Dollars ($5000) (Two Thousand Five Hundred Dollars ($2500) if married filing separate), (2) my spouse's earnings, if applicable, or (3) 50% of my earnings, whichever is least. I also understand that in order to receive reimbursement, I must submit receipts or other evidence that indicate who was cared for, dates of service, the actual amount paid along with the name, address and social security/tax identification number or the provider of these services. I understand that I or my spouse, if applicable, may not elect to receive the tax credit for the dependent care expenses that I have been reimbursed for under the Plan.

HEALTH CARE EXPENSES I understand that, for this Plan Year, I may be reimbursed for expenses incurred for my medical care and the medical care of my spouse and dependents which are not covered by medical insurance or other plans up to the maximum amount deemed by the Plan. The "dependent" relationship must exist when the charges were incurred. If I claim reimbursement for these expenses under the Plan, the amount of the reimbursement will be tax free.

Eligible medical expenses include any expenses incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure, prescription drugs or insulin.

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