

## HEALTH SAVINGS ACCOUNT (HSA) FLEXIBLE SPENDING ACCOUNT (FSA) AND DEPENDENT CARE ACCOUNT (DCA) ENROLLMENT FORM/CHANGE OF STATUS

**COMPANY NAME:** \_\_\_\_\_ **COMPANY ID:** CHO \_\_\_\_\_

Effective Date: \_\_\_\_\_ Date of First Payroll Reduction: \_\_\_\_\_

**Please check one:**  This is a regular annual election  
 I am a new employee  
 There has been a change in my family status  
 This is a termination

**Marital Status:**  Single  
 Married  
 Legally Separated  
 Widowed  
 Divorced

**Employment Date:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**Change is due to:**  Marriage  Death of spouse/child  
 Spouse became employed  Spouse ceases to be employed  
 Change in work hours  Unpaid Leave of absence  
 Divorce/separation  Birth or adoption of child  
 Change of address  Date change occurred: \_\_\_\_\_  
 Other (please explain): \_\_\_\_\_

**I participate in the health plan as a:**  Single  
 Employee & Spouse  
 Employee & Child  
 Family  
 I do not participate in the health plan

**Social Security Number:** \_\_\_\_\_

Last Name (please print)	First Name	MI	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street or PO BOX)	City	State	Zip
Phone Number	Email Address - Necessary to receive email communication on your account		

**List eligible dependents to be covered in order of age (including spouse)**

Last Name (if different)	First	MI	Relationship	DOB	Sex (M/F)	Full Time Student?	S.S. #

Health Savings Account (HSA) (reimbursement for health care expenses not paid from any other source)  
*Amount per pay period:* \$ \_\_\_\_\_ *Annual Election:* \$ \_\_\_\_\_

**PLAN YEAR ELECTION:** I authorize my employer to deduct a pre-tax contribution from my compensation for the following benefits:

Flexible Spending Account (FSA) (reimbursement for health care expenses not paid from any other source)  
*Amount per pay period:* \$ \_\_\_\_\_ *Annual Election:* \$ \_\_\_\_\_

Dependent Care Reimbursement Account (DCA) (day care expenses for eligible dependents)  
*Amount per pay period:* \$ \_\_\_\_\_ *Annual Election:* \$ \_\_\_\_\_

**AUTHORIZATION OR WAIVER OF PARTICIPATION**  
 I request to participate in the benefits indicated above. I understand that my **FSA & DCA** elections indicated above are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan. I further certify that any dependents for whom I will be claiming dependent care or health care expenses will be claimed by me as dependents on my federal and state tax returns. If I have waived participation, I understand that I may not join the Plan until the start of the next plan year.  
 Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses that are not covered by any other plan. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account. I understand that these expenses cannot be claimed on my income tax return. By signing this form I hereby authorize my employer to deduct any ineligible expenses paid for with *The Choice Care Card™* from my paycheck. I understand that any unauthorized use may result in the loss of my *The Choice Care Card™*.

I elect to participate in *The Choice Care Card™*  I do not elect to participate in *The Choice Care Card™*

**Direct Deposit (ACH):** When filing claims manually, I hereby authorize **The Choice Care Card** to Credit the account indicated below:  
 Account Number: \_\_\_\_\_ Transit Routing Number (9 digits): \_\_\_\_\_  
 Type of Account:  Checking  Savings

**By signing below I hereby authorize the release of claim information to my employer, their broker, and *The Choice Care Card™* administrator.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_