AMWINS™
CONNECT ADMINISTRATORS

Flexible Spending Account Enrollment Form

Effective Date: _____

Please complete all sections of the enrollment form and sign.

Section 1: Employee Information

Last Name:	First Name:	Middle Initial:	Social Security Number:
Date of Birth:	Gender: ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Divorced	Email Address:
Street (Include Apartment Number)			
City:	State:	ZIP Code (+4 if available):	Phone Number:

Section 2: Elections

☐ **Health FSA ($2,750 Maximum Annual Election)**

☐ I ***ELECT*** to participate ☐ I ***DO NOT ELECT*** to participate	Protect $ _____ annually from taxes Use the worksheet to determine the amount necessary to cover your annual expenses

Section 3: Authorization

I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible change in status. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. At the end of the plan year or date of my termination I will have a specified timeframe as defined by my employer to submit receipts for reimbursement for services received during the plan year or employment period.

I understand that any eligible costs that may be reimbursed directly to me by other plans are **not eligible** for reimbursement through the Flexible Spending Account.

Employee Name (printed): _____ Signature: _____

Section 4: Employer Section

Company Name:	Effective Date:	Plan Year From: