Seattle Human Resources

# 2024 Flexible Spending Account (FSA) Enrollment Form

## Employee Information: (Please print)

| Last Name | First Name |
|---|---|
| Employee # | Department |

## Enrollment Status*: (Please check one)

◯ **New Enrollment** ◯ **Re-enrollment** (Returning from Leave of Absence or mid-year Qualifying Event)

*Use this form **only** if you are unable to enroll via Employee Self-Service. If you can enroll online, a paper copy will not be processed.

## Coverage Options:

☐ **Option 1: Health FSA** (For eligible expenses not covered by medical, dental, or vision plan) Reset this section

**Contribution Options:**

- The **minimum** annual contribution is $120 *(regardless of participation start date)*
- The **maximum** annual contribution is $3,050

I authorize the City to deduct $_____ from my paycheck **each month** before federal taxes are withheld. I understand that the City will deduct **half** of my monthly contribution from the **first paycheck** and the **half** from the **second paycheck** each month. No deductions will be taken from the third paycheck of a month. I understand amounts elected for contribution cannot be revoked or modified mid-plan year except as explained in the materials provided.

☐ **Option 2: Day Care FSA** (For day care related expenses for eligible dependents) Reset this section

**Contribution Options:**

- The **minimum** annual contribution is $120 *(regardless of participation start date)*
- The **maximum** annual contribution is $5,000

I authorize the City to deduct $ _____ from my paycheck **each month** before federal taxes are withheld. I understand that the City will deduct **half** of my monthly contribution from the **first paycheck** and the **half** from the **second paycheck** each month. No deductions will be taken from the third paycheck of a month. I understand amounts elected for contribution cannot be revoked or modified mid-plan year except as explained in the materials provided.

**Note:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

**Acknowledgement signature required on the next page.**

## Coverage Acknowledgement:

My signature below indicates that I have read the enrollment form and descriptive materials, including the plan document, covering the Health Care and/or Day Care Flexible Spending Account programs provided by the City of Seattle. This enrollment form is binding on me and cannot be revoked or modified (other than as explained in the materials provided). I also understand that my salary will be reduced by the amount I have elected, that salary deductions occur twice per month (with no FSA deductions from the third paycheck in a month).

I also understand that this arrangement for paying eligible expenses with pre-tax dollars is intended to meet IRS requirements for such arrangements. If tax laws change or if this arrangement is deemed not to satisfy the requirements, I understand that the tax advantages described may not be available. I acknowledge that the City of Seattle makes no guarantee concerning the availability of any tax advantage.

Employee's Signature: Date (mm/dd/yyyy):

## Submit form to:

SHR Benefits Unit
Email: benefits.unit@seattle.gov
Questions: 206.615.1340