EMPLOYEE ENROLLMENT FORM

Flexible Spending Account (FSA)

Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected.

Email the completed and signed form to UMC Human Resources or email it to benefits@umcsn.com.

For Employer to complete where applicable:

Employer Name: **Clark County**

Employer TASC ID # _____

PRNR _____

Employer Department_____

Participant Plan Effective Date

First Payroll Date _____

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		MI:		Last Name:			
TASC ID # (if known):		Email Address[1]:					
Primary Phone #:		Mobile Phone #[1]:					
Primary Address	Address Line 1:				Apt:		
	Address Line 2:						
	City:						
	State:		ZIP/Postal Code:		+4		
Date of Birth:		Hire Date:		Payroll Frequency:	**Bi-Weekly**		

All fields are required for account setup. Information is confidential and is not used for marketing purposes.

[1]*Please provide this information if available (not required).*

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

I select the following benefits and amount(s) to be deducted pretax:		Employee Annual Election Amount		Employee Minimum Annual Election	Employee Maximum Annual Election
☐	**Healthcare FSA (Annual Election / 24 Pay Periods)**	**$**		$ 0	$3,200
☐	**Dependent Care FSA (Daycare Expenses) (Annual Election / 24 Pay Periods)**	**$**		$0	$5,000 $2,500 if married filing single

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** **(No fee)**	
2	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	

3	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

EMPLOYEE ENROLLMENT FORM
Flexible Spending Account (FSA)

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature: _____ Date: _____

ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable benefit account type:

1. **Healthcare FSA Election:** This amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental expenses, orthodontic expenses, eye care, and other eligible healthcare expenses. Per IRS regulations, a participant may elect a maximum based on the current IRS limits. Your employer may have a plan year maximum less than the IRS allowed amount. Review your Summary Plan Description (SPD) or check with your employer for your plan's maximum annual amount. Your annual election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement on the first day of the plan year as eligible expenses are incurred.
2. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the plan year. Your annual contribution must be within the maximum allowable amount under IRS regulations for a family or for married individuals filing single. Plan funds are available as they are contributed.

For assistance: call toll-free 800-422-4661

Have your enrollment form, employer name, and the Client ID# ready.

Find all IRS limits on our resource web page: https://www.tasconline.com/benefits-limits/

TASC | 2302 International Lane | Madison, WI 53704-3140 | 1.800-422-4661 | www.tasconline.com | FX-2008-090519

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose.

©TASC