BPA Benefit Plan Administrators
402 Graham Avenue, PO Box 1128
Eau Claire, WI 54702-1128
Phone: (715)-832-5535 Fax: (715)-838-8507

FLEXIBLE SPENDING ENROLLMENT FORM

Employee's First Name	MI	Last Name	SSN

Employee's Home Address (Street, City, State, Zip)	Home Phone

Date of Birth	Gender	Marital Status	Plan Enrolled In	Spouse's Name
	☐ Male ☐ Female	☐ Single ☐ Married	☐ Medical Flex ☐ HRA ☐ Limited Flex ☐ DCA	

Employment Date	Employer Plan Effective Date	Employee's E-Mail Address

Dependent(s)	Relationship	Birth Date	Social Security Number

(Employer Completes Shaded Sections)			☐ Limited Plan ☐ 12 Month Plan ☐ Short Plan Year	# of Payroll Deductions From Effective Date to End of Plan Year
Employer				
Group Number	Location Number	Group Insurance Premium(s) Per Pay Period Deduction	Date of First Deduction	Employee Effective Date for Plan

I request the following amounts to be deducted pretax:

A. Group Medical Premiums

For all years subsequent to your initial enrollment, if you participate in your employer's insurance plan(s), your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department.

Reimbursement Sections:	Annual Total		# of Pay Periods		Per Pay Period
B. Medical Reimbursement Account:		÷		=	
C. Dependent Care Reimbursement Account:		÷		=	
TOTALS:		÷		=	

Yes, I want to enroll. The IRS regulation states four conditions. **1)** Any expenses you incur must be within the plan year. **2)** Any expenses you incur must not be covered by any other source such as insurance. **3)** You must provide proper documentation in order to receive payment. **4)** You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. Please see the Summary Plan Description.

Note: Enrolling may have a minor effect on your Social Security benefits. Please seek appropriate advice.

Signature: X _____ **Date:** _____

☐ **No, I do not want to enroll in the reimbursement sections.**

If a change of status occurs, I may have the right to sign on the plan at that time if my employer's plan allows.

Signature: X _____ **Date:** _____