



TOOELE CITY CORPORATION
2021 – 2022 FLEXIBLE SPENDING ACCOUNT
Enrollment/Change Form

Name: _____ SSN: _____ Department: _____

Mailing Address _____
 Street City State Zip Code

Phone: _____ Mobile: _____ Email: _____

ADDITIONAL FLEX CARDS (Flex Cards do not expire for three years. Please do not throw away. \$10 replacement fee charged.)

List spouse and/or dependents with access to your Flex account.

NAME: _____ SSN: _____ RELATIONSHIP: _____

NAME: _____ SSN: _____ RELATIONSHIP: _____

<input type="checkbox"/> Re - Enrolling	Complete below Flexible Benefit Plan Election
<input type="checkbox"/> New Enrollee	DATE OF HIRE: _____ CHECK DATE OF FIRST PAYROLL DEDUCTION: _____
<input type="checkbox"/> Notice Of Change	DATE OF CHANGE: _____ CHECK DATE OF FIRST PAYROLL DEDUCTION: _____ Complete below Flexible Benefit Plan Election REASON FOR CHANGE (Life Event**): <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption of Dependent <input type="checkbox"/> Employment Change <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Benefit Change _____
<input type="checkbox"/> Termination	DATE OF TERMINATION: _____ CHECK DATE OF LAST PAYROLL DEDUCTION: _____

FLEXIBLE BENEFIT PLAN ELECTION

<input type="checkbox"/> Health Care Flexible Spending Reimbursement Account Elected withholdings not to exceed \$2,500.00 annually.	\$ _____ Pay check \$ _____ Annually
<input type="checkbox"/> Dependent Care Reimbursement Account (daycare) The IRS allows a pre-tax withholding up to \$5,000 per year, per household. Age of Child(ren) not to exceed 12 yrs. old _____	\$ _____ Pay check \$ _____ Annually

Whereas, the employee desires to obtain benefits of IRS sections 105, 106, and 125 and other sections as amended that provide benefits, and whereas employer is willing to assist employee in obtaining such benefits, now, therefore, it is normally agreed employee's cash compensation per pay check shall be reduced by \$ _____ * effective with the pay check issued on _____.

Employer will apply the amount by which cash compensation is reduced to provide benefits as described in the Enrollment and Election Form. If employee's employment is terminated, this agreement will terminate. I elect the benefits indicated above and authorize my employer to reduce my compensation by the amount necessary to pay for the benefits I have elected. I understand the following:

- 1 My election for the Health Care and Dependent Care Reimbursement Accounts may not be changed or revoked until the next plan year or a life event (change in status or income)** occurs.
- 2 Manual reimbursements will be processed every 5th day of the month. Eligible expenses can be processed by the "Flex Convenience" debit card. ***Save all receipts – as per guidance from the IRS, random audits will be performed.*** If ineligible expenses are discovered, the amounts to compensate for the misuse of funds will be withheld from payroll.
- 3 **All expenses must be submitted for reimbursement no later than three months after the end of the plan year. Once all eligible expenses have been reimbursed I forfeit any amounts left in the Health Care or Dependent Care Accounts, with the exception of the rollover allowance on my Health Care Account of up to \$500.**
- 4 My "Flex Convenience" debit card is valid for 3 years. I will be responsible to pay a \$10 replacement fee for lost or stolen debit cards.
- 5 Amounts reimbursed by any other source not eligible, i.e., benefits paid by insurance or through an, HSA or HRA.

EMPLOYEE

EMPLOYER

Signature Date

Signature Date

I have been offered and decline this benefit at this time.

*A total of the Health Care and Dependent Care Account deposits

**DIRECT DEPOSIT AUTHORIZATION
FOR MANUAL REIMBURSEMENTS**

Direct deposit is not required for Flex participation, but is required for manual claim reimbursement.

I hereby authorize Flex, a Service of Goldenwest, to initiate entries to my checking/savings accounts at the financial institution listed below. This authority will remain in effect until Flex, a Service of Goldenwest is notified by me in *writing*. All ACH credit authorizations or changes require ten business days for processing before they become effective. **If I fail to notify Flex, a Service of Goldenwest of changes in my financial institution, I am responsible for any applicable return/rejection fees (\$15.00).**

(Name of Financial Institution)

(Address of Financial Institution - Branch, City, State, & Zip)

(Signature)

(Date)

(Name - PLEASE PRINT)

(Address - PLEASE PRINT)

Account Type (circle one) Checking or Savings

Account Number: _____

Financial Institution Routing Number: _____

These numbers are located on the bottom of your **check** (not deposit slip) as follows

⑆ 123456789 ⑆ 1234567890123 ⑆
Routing Number Account Number

Please send completed form and a **VOIDED check** to:

Flex, a Service of Goldenwest
315 N Marketplace Dr.
Centerville, UT 84014
(801)786-8160 or (888) 532-3412
Fax (801) 292-4041
flex@gwcu.org

