Archdiocese of St. Louis Health Insurance
Employee Flexible Spending Plan Election Form

COMPLETED BY EMPLOYER: Please check one of the following:

❒ Open Enrollment Election **(July 1, 2023 through June 30, 2024)**
❒ New Hire Employee **(Plan Year July 1, 2023 through June 30, 2024)**
❒ Qualifying Event: Change of Contribution Payroll Deduction or Termination of Plan

Effective Date **Qualifying Event for Change**

Date of first paycheck affected

Parish / School / Agency Employer Name

Parish / School / Agency Address

1. EMPLOYEE INFORMATION

Last Name	**First Name**	**MI**	**Date of Birth** **Gender** ❒ Male ❒ Female
Home Mailing Address			**Social Security Number** xxx-xx-
City	**ST**	**Zip Code**	**Marital Status** ❒ Married ❒ Unmarried
Home Telephone Number			**Date Employed**

2. I elect to allocate the following: MEDICAL REIMBURSEMENT PLAN

Medical Reimbursement Plan (Do not include employee health insurance premium contributions) Maximum Allowable Account Amount is $3,050 per Plan Year

Annual Amount ____

Total $ amount for the FSA plan year

**total will be divided among remaining pay periods in the FSA plan year*

3. I elect to allocate the following: DEPENDENT CARE REIMBURSEMENT PLAN

Dependent Care Reimbursement Plan

Maximum Allowable Account if Single, Head of Household or Married, Filing Joint Return is $5,000 per Plan Year

Maximum Allowable Account amount if Married, Filing Separate Return is $2,500 per Plan Year.

Annual Amount ____

Total $ amount for FSA plan year

**total will be divided among remaining pay periods in the FSA plan year*

4. DESIGNATE YOUR BENEFICIARY

I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible spending account should be made payable to the undersigned.

Primary Beneficiary Name **Relationship**

Contingent Beneficiary Name **Relationship**

5. READ AND SIGN

My signature on this form certifies that I have received and read the printed material explaining my employer's flexible spending program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (i.e., marriage, divorce, birth or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.

Signature of Applicant _____ **Date** _____

Please submit your completed and signed FSA Election Form via fax to 314.792.7548

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