



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.
Return the completed and signed form to your employer for processing.

For Employer to complete where applicable:

Employer Name _____ Employer TASC ID # _____
 Employer Class _____ Employer Division _____
 Participant Plan Effective Date _____ First Payroll Date _____

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

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:		

I do not wish to actively participate in Dependent Care FSA.

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 Salary Reduction Election Amount	Employee Minimum Annual Election	Employee Maximum Annual Election
<input type="checkbox"/> Healthcare FSA	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Dependent Care FSA (Daycare Expenses)	\$ _____	\$ _____	\$ _____ \$2500 if married filing single
<input type="checkbox"/> Healthcare Premium (NESP) Reimbursement Account	\$ _____	\$ _____	\$ _____

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 ****



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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.
- 3. Healthcare Premium (NESP) Reimbursement Account Election:** The total annual out-of-pocket cost for privately purchased (individual) insurance **premiums** such as health, disability, and cancer insurance. Other medical expenses are **not** eligible under the NESP Account. Examples of insurance premiums NOT eligible are employer-sponsored group insurance (premiums deducted from your paycheck or your spouse's paycheck), life insurance, long-term care insurance, and premiums for coverage under the federal exchange "Marketplace" program. Please note, when disability premiums are pre-taxed, the benefits received are taxable. NESP is not subject to contribution limits unless otherwise set by your Employer but is subject to the 'Use it or Lose it' rule in which unused funds are forfeited at year-end. NESP Account funds are available as they are contributed.

For enrollment 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/>