Blue Cross Blue Shield of Rhode Island

Please Send Completed Form To:

By Mail:
Department of Human Resources
North Campus Building
One Old Ferry Road
Bristol, RI 02809

By Email:
human_resources@rwu.edu

Flexible Spending Account (FSA) Enrollment Form

Employee Information:

Employer Name:		Effective Date:	
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
Email Address:	Phone #:		
Date of Birth:	Social Security #:		

Dependent/s Information:

Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No

** Please list additional dependents on back side of this enrollment form*

Employee's Flexible Benefit Per Pay Deduction / Allocation:

Medical Reimbursement Account: Per Pay Period $ _____ # of Pay Periods_____

$2,650.00 Maximum Annual Contribution* Annual Contribution $ _____ Date of First Payroll_____
(set by IRS)

**The maximum amount may change for 2019. If you want your annual amount to automatically increase to the maximum, please check this box:* ☐

Dependent Care Reimbursement Account: Per Pay Period $ _____ # of Pay Periods_____

$5,000.00 Maximum Annual Contribution* Annual Contribution $ _____ Date of First Payroll_____
(set by IRS)

**The maximum amount may change for 2019. If you want your annual amount to automatically increase to the maximum, please check this box:* ☐

Commuter Reimbursement Account: Per Pay Period $ _____ # of Pay Periods_____

$260.00 Maximum Monthly Contribution* Annual Contribution $ _____ Date of First Payroll_____
For Parking *(set by IRS)*

$260.00 Maximum Monthly Contribution* Per Pay Period $ _____ # of Pay Periods_____
For Transit *(set by IRS)* Annual Contribution $ _____ Date of First Payroll_____

**The maximum amount may change for 2019. If you want your monthly amount to automatically increase to the maximum, please check this box:* ☐

I Understand That:

(1) My employer will be deducting the allocations stated above from pay check for the purposes of funding my Flexible Spending Account plan(s).

(2) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for each new plan year.

(3) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status, marriage, divorce, death of spouse or child, birth or adoption of child, termination or commencement of employment of a spouse, or such other qualifying events allowed by the Internal Revenue Code that will permit a change or revocation of an election.

(4) London Health Administrators may reduce, cancel, or otherwise modify this agreement in the event they believe it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

(5)This agreement is subject to the terms of the Company's Flexible Spending Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

(6) By signing this form, I agree to the terms and procedures listed herein.

Employee Signature: _____ **Date:** _____