FSA FORM INSTRUCTIONS

Attached is the 2021 Flexible Spending Health, Dependent Care and Commuter enrollment form.

The form is set up to be completed electronically. For your convenience, some of the needed information is already on the form (such as effective dates).

Please complete the form as follows:

- Complete the fillable fields in the first two sections with your personal information.

- In the Deduction/Allocation section,

  1. **Check the Box(es)** of the account(s) you are enrolling in;

  2. For the **Annual Contribution**, simply type in the dollar amount (digits only) next to the account(s) you checked off and the form will calculate your Pay Period amount automatically;

  3. **E-sign and Date** the form; and

  4. **Return to Human Resources no later than November 30th**:

Email to: human_resources@rwu.edu or

Fax to: Human Resources at (401) 254-3370

Please Send Completed Form To:
Human Resources
One Old Ferry Road, Bristol, RI 02809
Email: human_resources@rwu.edu
Phone: 401-254-3028
Fax: 401-254-3370

Flexible Spending
Dependent Care and Commuter Account
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 No. (Last 4 Digits):		

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
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:
$2,750.00 Maximum Annual Contribution* *(set by IRS)*
Annual Contribution:
Per Pay Period:
# of Pay Periods _______
Date of First Payroll _________

Dependent Care Reimbursement Account:
$5,000.00 Maximum Annual Contribution* *(set by IRS)*
Annual Contribution:
Per Pay Period:
# of Pay Periods _______
Date of First Payroll _________

Commuter Reimbursement Account:
$270.00 For Parking — Maximum Monthly Contribution* *(set by IRS)*
Annual Contribution:
Per Pay Period:
# of Pay Periods _______
Date of First Payroll _________

$270.00 For Transit — Maximum Monthly Contribution* *(set by IRS)*
Annual Contribution:
Per Pay Period:
# of Pay Periods _______
Date of First Payroll _________

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:** ______________________

Plan Administrator: London Health Administrators

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