HMA HEALTHCARE MANAGEMENT ADMINISTRATORS

HealthEquity

Flexible Spending Account (FSA) Enrollment Form

Plan Year 8/1/2020 – 7/31/2021

Employee Last Name _____First Name _____MI _____

Member ID or SSN _____ Group Number: Baden Sports, HMA group #4078

Home/Mailing Address _____

City, State, Zip _____

☐ New Enrollment ☐ Open Enrollment ☐ Coverage Change → Reason for Change: _____
Date of Life Event: _____

FSA Elections	Annual Election	Number of Paychecks	Deduction per Paycheck
Health Care Flexible Spending Account The maximum contribution is $2,750.	$_____	_____	$_____ / paycheck
Dependent Care Flexible Spending Account The maximum contribution is $5,000.	$_____	_____	$_____ / paycheck

By signing this salary reduction agreement, I certify that:

- I understand that my election amount for the year cannot be changed except under qualifying change in family status,
- I understand that all money remaining in my account(s) at the end of the plan year can be forfeited depending on my employer's plan,
- I understand that my election will be withheld evenly from each paycheck during the Plan Year on a pre-tax basis, and that this may result in it being slightly less than I have listed here due to rounding,
- I understand that my Dependent Care election cannot exceed the annual salary of myself or my spouse (if married) nor $5,000,
- I understand that if I am a highly compensated employee all or a portion of my benefit may be deemed taxable as a result of non-discrimination testing.

_____ _____

Employee Signature Date

Employer Approval: _____ Date:_____ Effective Date of Change: _____