Flexible Spending Account (FSA) Election Form

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____ Personnel # _____

Address **(Physical)** _____ City _____ State _____ Zip _____

Phone (____) _____ Email Address _____ Social Security Number _____

Payroll Effective Date _____ / _____ /_____ mm/dd/yyyy

Agency / School _____

☐ New Hire ☐ Open Enrollment ☐ Qualifying Event

Section 2: FSA Election and Annual Amount

I choose to participate in Flexible Spending Account.

☐ Health FSA – Medical Expenses ..... $ (Annual Amt.) _____ / 26 Pay Periods

☐ Limited Purpose FSA - Dental and Vision (Available only with HSA enrollment)..... $ (Annual Amt.) _____ / 26 Pay Periods

DCAP/Dependent Care FSA

☐ DCAP/Dependent Care FSA (Daycare/Elderly Care) Expenses..... $ (Annual Amt.) _____ / 26 Pay Periods

Section 3: Adoption Agreement / Employee Signature

I hereby authorize and direct my employer to reduce my earnings in the amount necessary to fund my Cafeteria Plan as indicated below. I understand such reductions, considered elective contributions under the Plan, will start with my first paycheck dated after the plan year begins. I understand that the purpose of this program is to allow employees to select qualified benefits within the guidelines of the Internal Revenue Code. I also understand that the flexible spending account plan(s) will allow me to be reimbursed for eligible out-of-pocket medical, dental, vision and/or dependent care expenses.

I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in my family status. I hereby certify the above information to be correct and true and I choose to participate.

Signature of Account Holder _____ Date ____ / _____ /_____

Visit ARBenefits Member Portal for online enrollment, or submit the paper form to EBD, by Fax: 501-683-0983, or mail ARBenefits, PO Box 15610, Little Rock, AR 72231, or provide to your HR Rep to submit. mm/dd/yyyy
For enrollment questions, please call toll-free at 877-815-1017, or email Ask.EBD@arkansas.gov.

Custodian
DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Plan Service Provider
Beneliance
www.beneliance.com
Serial No. 666576474227

State of Arkansas Employee Benefits Division
Toll Free: 877-815-1017 | Fax: 501-683-0983
Mailing: ARBenefits
PO Box 15610
Little Rock, AR 72231