

State of Arkansas FSA Election Form

Follow these easy steps:

1. Complete all entries on this Enrollment Form. Please print.
2. Sign and date this form.
3. Submit it to your Human Resources Department

For Employer Use	
Date of Hire (MM/DD/YYYY)	<input type="text"/>
Benefits Effective Date (MM/DD/YYYY)	<input type="text"/>
Department Information	
Department Name	<input type="text"/>
Department Number	<input type="text"/>

Personal Information

Employee Name (last name, first name)	<input type="text"/>	Social Security Number	<input type="text"/>
Street Address (cannot be PO Box)	<input type="text"/>	City, State, Zip Code	<input type="text"/>
Mailing Address (if different)	<input type="text"/>	City, State, Zip Code	<input type="text"/>
Day Time Phone Number	<input type="text"/>	Email Address	<input type="text"/>
Date of Birth (MM/DD/YYYY)	<input type="text"/>	Enrollment Status	<input type="checkbox"/> New enrollment <input type="checkbox"/> Re-enrollment
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

Health Flexible Spending Account (FSA)	Dependent Care Assistance Plan (DCAP)
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<input type="checkbox"/> Select FSA <input type="checkbox"/> Decline FSA	<input type="checkbox"/> Select DCAP <input type="checkbox"/> Decline DCAP
I. Annual Contribution (Not to exceed IRS limits*) <input type="text"/>	I. Annual Contribution (Maximum Contribution: \$5,000) <input type="text"/>
II. Number of regular pay periods <input type="text"/>	II. Number of regular pay periods <input type="text"/>
III. Contribution per pay period (I divided by II) <input type="text"/>	III. Contribution per pay period (I divided by II) <input type="text"/>
IV. Type of Health Care FSA <input type="checkbox"/> General Purpose - covers medical, prescription, OTC, dental and vision expenses. Not compatible with a Health Savings Account (HSA). <input type="checkbox"/> Limited Purpose - covers dental and vision expenses only. Compatible with a Health Savings Account (HSA).	

Authorization and Certification

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Funds left in my Dependent Care Account at the close of the plan year will be forfeited. Funds left in my Health Flexible Spending Account may be forfeited, per plan rules. See plan documents for more details.

I will receive a ConnectYourCare Payment Card to access funds in my account. I certify that:

- The card will only be used for eligible medical and/ or dependent care expenses.
- Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

Employee Signature

Date

*Health FSA contributions are limited by the IRS. The limit is per person; a married couple may each contribute up to the specified limit. For 2020, the limit is \$2,750.