inspira™ FINANCIAL

Reimbursement Accounts Flexible Spending Account (FSA) Limited Purpose Flexible Spending Account (LPFSA) Enrollment Form

Employer Use Only
Employer ID Number _____
Re-enrollment ☐ **New** ☐ **Change** ☐
Effective Date _____
1st Payroll Deduction Date _____
Payroll Mode W☐B☐S☐M☐Q☐
Division Code _____

A. Personal Information (Be sure to print clearly and complete each section.)

Employer Name			
Employee First Name	**MI**	**Last Name**	**Employee Social Security Number**
Employee Street Address			
City		**State**	**ZIP Code**
Employee email		**Date of Birth** (MM/DD/YYYY)	**Date of Hire** (MM/DD/YYYY)

B. Election Information (Check the box to tell us if you wish to enroll or not.)

☐ **Yes, I wish to participate in the Benefit Choice(s) offered below. I authorize payroll deductions on a pre-tax basis in the amount(s) listed below. I know this election is for the entire Plan year.**

☐ **No, I don't wish to enroll in either Benefit Choice at this time.**

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Flexible Spending Account (FSA) • Your employer's Plan sets the minimum and maximum contribution amounts, up to the Internal Revenue Service (IRS) limit. • If you're enrolled in a Health Savings Account (HSA), you can't enroll in a Health Care FSA.	$_____._____	x	_____	=	$_____._____
Limited Purpose Flexible Spending Account (**LPFSA**) • Available if you're enrolled in a Health Savings Account (HSA).	$_____._____	x	_____	=	$_____._____

By signing this, you agree to the following statements:

- I know that if I or my spouse has an HSA, I may only participate in a Limited Purpose FSA.
- I know this election is for the entire Plan year.
- I know that the only way to change my election during the Plan year is if I have a change in status or become ineligible to participate. The new election must be consistent with my change in status. I must apply for it within 30 calendar days of the change or as allowed by the Plan, and my employer must approve it.
- My employer will change or cancel this election, if needed, to comply with the Internal Revenue Code.
- I know that I will forfeit any amounts left in my account at the end of the Plan year, unless my Plan allows carryover for the FSA or LPFSA. This is defined in the Plan.
- I know that funds cannot be transferred between these accounts.
- I know that for FSA I need to complete and submit a new Enrollment Form for each Plan year. If I don't complete and return an Enrollment Form during Open Enrollment, I won't be able to participate in these accounts for that Plan year.
- If I elect the FSA I understand that when I elect pre-tax salary deductions, Social Security and Medicare taxes are not withheld from those amounts.
- If I elect the FSA/LPFSA I understand that I can't claim the amount of salary deductions on my or my spouse's income tax returns.
- I know that if my employment ends, I can only claim medical expenses incurred through my period of coverage. This is defined in the Plan.
- I know that I have to include documentation with each claim to show that the expense is eligible for reimbursement.
- If I use my Inspira Financial Debit Card, I agree to use the card for eligible expenses only and to keep all itemized receipts and statements. I agree to read and adhere to the cardholder statement I receive with the card. I know the card may be turned off if I don't comply with the card rules or if my employment ends and I no longer have this account.
- When I use my Inspira Financial Debit Card or submit a claim, I haven't been reimbursed and I won't seek reimbursement elsewhere.

C. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ **I authorize Inspira Financial to initiate a credit and/or debit entry to my account for my Inspira Financial reimbursements.**
This agreement is to remain in full effect until written notification is supplied by me to Inspira Financial terminating this agreement. Inspira Financial cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.

A "VOIDED" CHECK OR SAVINGS DEPOSIT SLIP MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

Employee Signature _____ **Date** _____