



Archdiocese of St. Louis Health Insurance Employee Flexible Spending Plan Election Form

COMPLETED BY EMPLOYER: Please check one of the following:

- Open Enrollment Election (July 1, 2022 through June 30, 2023)
- New Hire Employee (Plan Year July 1, 2022 through June 30, 2023)
- Change of Contribution Payroll Deduction or Termination of the plan

Effective Date _____ **Qualifying Event for Change** _____

Date of first paycheck affected _____

Parish / School / Agency Employer Name _____

Parish / School / Agency Address _____

1. EMPLOYEE INFORMATION	Last Name	First Name	MI	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Home Mailing Address				Social Security Number XXX-XX-	
	City	ST	Zip Code	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried		
	Home Telephone Number				Date Employed	

2. MEDICAL REIMBURSEMENT PLAN	Medical Reimbursement Plan (Do not include employee health insurance premium contributions) Maximum Allowable Account Amount is \$2,850 per Plan Year					
	I elect to allocate the following on a monthly basis:	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	÷	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	=	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>
	Payroll Deduction Amount	Total Annual Before-Tax Dollars		# of Payroll Periods remaining in Fiscal Plan Year		Contribution per Paycheck

3. DEPENDENT CARE REIMBURSEMENT PLAN	Dependent Care Reimbursement Plan				
	Maximum Allowable Account if Single, Head of Household or Married, Filing Joint Return is \$5,000 per Plan Year Maximum Allowable Account amount if Married, Filing Separate Return is \$2,500 per Plan Year.				
	I elect to allocate the following on a monthly basis:	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	÷	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	=
Payroll Deduction Amount	Total Annual Before-Tax Dollars		# of Payroll Periods remaining in Fiscal Plan Year		Contribution per Paycheck

4. DESIGNATE YOUR BENEFICIARY	I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible spending account should be made payable to the undersigned.	
	Primary Beneficiary Name	Relationship
	Contingent Beneficiary Name	Relationship

5. READ AND SIGN	My signature on this form certifies that I have received and read the printed material explaining my employer's flexible spending program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (i.e., marriage, divorce, birth or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.	
	Signature of Applicant _____	Date _____

Please submit your completed and signed FSA Election Form via fax to 314.792.7548 or by mail to Archdiocese Office of Human Resources, 20 Archbishop Dr., St. Louis, MO 63119.