

HSA/FSA Annual Tax Free Enrollment Form

Section I - Employee Information

Employer Name: CITY OF KETTERING		Plan Year: 2012	Department:
Employee Name:		Gender: M or F (Circle One)	Social Security #
Street:	City:	State:	Zip:
Birth Date:	Hire Date:	HDHP Eff Date: 01/01/2012	# of Pay Periods Per Year: 26

Section II - Group Insurance Premium and/or HSA Contribution

Your Group Insurance plan premiums are withheld pre-tax automatically. Your election to pay your Group Insurance premium automatically continues each year. HSA contributions may be changed anytime during the year.

Section III - HSA Contributions

<p style="text-align: center;">2012 Maximum Annual Contributions</p> <p>Single = \$3,050 Family \$6,150 If 55 and older, additional catch up contribution of \$1,000 is permissible</p> <p>Full HSA contribution regardless of month individual becomes eligible. Individuals who become covered under an HSA-eligible plan in a month other than January may make the maximum HSA contribution for the year based on their coverage in the last month of the year. If an individual does not stay in the HSA-eligible plan 12 months following the last month of the year of the first year of eligibility, the amount which could not have been contributed except for this provision will be included in income and subject to a 10 percent additional tax.</p> <p>If an individual becomes covered by other first dollar coverage and/or terminates HSA-eligible coverage during a calendar year, the maximum contribution is prorated based on the number of months they are eligible in that calendar year. However, HSA contributions may be changed anytime during the year.</p>	<p>\$ _____</p> <p style="text-align: center;">per pay</p> <p style="text-align: center;">X 26 =</p> <p>\$ _____</p> <p style="text-align: center;">per year</p>
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Section IV - FSA Health Care Account (Maximum Contribution is \$5,000) - Please Choose One:

<input type="checkbox"/> I do not wish to participate.	<p>Type 1. I do not and will not contribute to a Health Savings Account (HSA) in my name; nor does my spouse contribute to an HSA.</p> <p>I elect:</p> <input type="checkbox"/> General-purpose FSA for medical, vision and dental expenses.	<p>Type 2. My spouse contributes to a Health Savings Account. I do not contribute to an HSA.</p> <p>I elect General Purpose FSA (medical, vision, dental) for:</p> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee & children	<p>Type 3. I contribute and / or my spouse contributes to a Health Savings Account.</p> <p>I elect:</p> <input type="checkbox"/> Limited FSA for dental and vision expenses only.	<p>\$ _____</p> <p style="text-align: center;">per pay</p> <p style="text-align: center;">X 26 =</p> <p>\$ _____</p> <p style="text-align: center;">per year</p>
<p>Note Name of Spouse: _____</p>				

Section V - Dependent Child (up to 13th birthday) or Adult Day Care Reimbursement Account

<p>In order to participate in the Dependent Care Spending account, you must meet the following criteria:</p> <ul style="list-style-type: none"> • You and your spouse must both be working, seeking gainful employment or be a full-time student to be eligible to participate in the plan. • Your contribution may not exceed your earned income, nor your spouse's earned income. • In the situation of divorce, only the Custodial parent may use this account. • If you are single or are married/filing a joint tax return, the maximum permissible election per calendar year is \$5,000. If you are married/filing separately, the maximum is \$2,500 per calendar year. 	<p>\$ _____ per pay</p> <p style="text-align: center;">X 26 =</p> <p>\$ _____ per year</p>
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Section VI - Authorization

I understand my insurance premium and Health FSA election may only be changed during the Plan Year for certain "life events" such as marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, or termination of employment (except for the Health Savings Account contribution). Changes must be made within 30 days of the event.

I understand that if I own an HSA, I am responsible for knowing and abiding by all of the rules and regulations.

Generally you cannot change your dependent care election unless you have a change in status such as a change in cost or provider. Changes must be made within 30 days of the event.

Participation in this program may reduce my future Social Security benefits.

These are my pre-tax elections for the Plan year. I authorize my employer to make automatic payroll deductions of the amounts shown above from my earnings each pay period.

I understand I must provide qualifying receipts in order to receive reimbursement.

I understand that unused balance left in my Flexible Spending Account and/or Dependent Care Account at the end of the Plan year cannot be returned to me. I have read and understand the description of the Plan.

Date _____ Employee Signature _____

Section VII - To Be Completed By Employer

Effective date of Participation: 01/01/2012	Date of 1st payroll deduction: 01/06/2012	FlexBank Administrators, Inc. Phone: 937.299.5515 ~ Free: 888.677.8373 Revised 10/11
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