

If you would like to enroll in the flexible spending account (FSA) plan, please complete the following form and return it to a Human Resources contact in your organization.

- Annual Open Enrollment
 Mid-Year Enrollment-New Hire
 Change of Status (choose reason below)
 Birth/Adoption
 Marriage
 Divorce
 Leave of Absence
 Death of Participant
 Death of Spouse/Dependent
 Job Change
 Spouse Job Change
 Return from Leave of Absence

Employer Name: _____ Work Location: _____

Name: _____ Social Security Number: _____

Address: _____ Date of Hire: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Email Address: _____ Phone #: _____ W / H

List tax dependents eligible for benefits:

Name (First, Last)	Full Time Student?	Gender	Date of Birth	Relationship
Spouse				
Dependent				
Dependent				
Dependent				

Choose your Election Amount:

Please withhold the annual election amount below as pre-tax deductions from my paycheck during the designated plan year for deposit to the designated flexible spending account.

Plan Year: _____ Effective Date on Plan: _____

Initials	Benefit	Total Annual Election
_____	Medical Flexible Spending Account	\$ _____ /annually
_____	Dependent Care Flexible Spending Account	\$ _____ /annually

This Agreement intends to conform with Sec(s). 79, 105, 106, 125, 129 of the I.R.S. Code providing employee benefits. As provided for in said Sections, Employer has created a Cafeteria Plan to provide Employee with benefits. Employer and Employee mutually agree as follows:

- I. Employee's per pay cash compensation shall be redirected by the amounts listed below effective the first pay period beginning on or after Employee becomes eligible for benefits and shall continue until this Agreement is amended or canceled. Employee's elections and participation shall be governed by the terms of the Dependent Care Reimbursement and Health Care Reimbursement Plans as amended from time to time.
- II. Redirected salary must reimburse expenses incurred during Plan Year and may not be carried into future years. Any amount not reimbursed for the current Plan Year will be returned to the Employer's general fund. If employment is terminated, this Agreement terminates; however, Employee retains the right to benefits in accordance with the Plan Document.
- III. By offering this Plan, the Employer has provided no tax advice regarding participation in this Plan, therefore, the Employee waives any claims against the Employer and holds the Employer harmless for any taxes or assessments that may be imposed by the Internal Revenue due to future interpretations or changes in the laws governing these Plans.

Accepted by Employee

Signature _____

Date _____

For Employer Use Only

First payroll reduction date: _____

Payroll Frequency: _____

QUESTIONS? Contact Genesis Employee Benefits:

Local Phone: 952-653-4422

Toll-Free:

866-678-8322

CustomerCare@GenesisBenefits.net

**DIRECT DEPOSIT
AUTHORIZATION**

I hereby authorize Genesis Employee Benefits to initiate deposit of my medical and/or dependent care expense reimbursements to the bank account indicated below and, if necessary, debit entries and adjustments for any credit entries made in error to my account.

Please attach a copy of a voided check if you are electing to have reimbursement sent to a checking account.

If you are electing to use your savings account please contact your bank for the Transit ABA Routing Number.

If you are re-enrolling during Open Enrollment and are already signed up for direct deposit, you do not have to complete this form. We will continue to deposit reimbursements to the bank account on record.

This account is (Please check one of the following options)

New _____ Change _____ Cancel _____ Name of Bank: _____

Transit ABA Routing Number _____ Account Number _____ Account Type (Checking or Savings) _____

**Attach
Voided Check
OR
Savings Deposit Slip
HERE**

Bobby Brady 123 Main Street Anywhere, USA 55439	3448 7-1-945
Pay to the Order of _____	Date _____
_____ Dollars	
For _____	
:091000019 :3564895891" 3448	

(Routing Number) (Account Number)

Employer Name: _____ Address Change

Employee Name: _____ SSN: _____

Home Address: _____

Email Address: _____ Telephone: _____

Signature _____

Date _____

FAX, EMAIL OR MAIL this form to:

Local Claims eFax: 952-460-1480

Toll-Free Claims eFax: 866-450-1480

Email: Claims@GenesisBenefits.net

Genesis Employee Benefits, Inc

PO Box 1578

Minneapolis, MN 55440-1578

Local Phone: 952-653-4422

Toll-Free Phone: 866-678-8322

CustomerCare@GenesisBenefits.net

Check the status of your claim online at www.GenesisBenefits.net. Choose Participant Login in the upper right corner.