PriorityFSA℠
Enrollment/Change Form

Attention: ASO Flex MS 2260
1231 East Beltline NE • Grand Rapids, MI 49525-4501

PriorityHealth®

I am completing this form for (check all that apply):

☐ FSA enrollment ☐ Limited FSA enrollment (for use with a HSA health plan) ☐ Name/address change ☐ FSA election change

Section 1 - Employee information

Complete each item in this section.

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP	PHONE
EMPLOYER NAME	GROUP NUMBER	GENDER ☐ MALE ☐ FEMALE	BIRTH DATE: / /	

Section 2 - Dependent information (required for all dependents eligible for FSA reimbursements)

Complete each item with your spouse and dependent(s) information.

	Social Security Number	Last name	First name	M.I.	Gender	Birthdate	Relationship to employee
1 - SPOUSE					☐ MALE ☐ FEMALE		
2 - DEPENDENT					☐ MALE ☐ FEMALE		
3 - DEPENDENT					☐ MALE ☐ FEMALE		
4 - DEPENDENT					☐ MALE ☐ FEMALE		

Please attach a separate document listing additional dependents and their information. Dependents not listed will not be eligible for automatic FSA reimbursements.

Section 3 - Flexible Spending Account enrollment and pre-tax elections

Check the appropriate box for enrollment or to decline enrollment. Enter your total annual contribution amount in the box marked "Annual election amount." Your annual maximum may not exceed the lesser of your earned income, spouse's earned income or employer's maximum amount.

HEALTH CARE ACCOUNT: See your employer materials for election maximum ☐ **YES** - I wish to participate in the health care account (Please place election to the right) ☐ **NO** - I decline to participate in the health care account	Annual election amount $
DEPENDENT CARE ACCOUNT: Annual maximum up to $5,000 (however, your elected amount cannot be greater than you or your spouse's earned income OR $2,500 if you are married but file a separate tax return from your spouse) ☐ **YES** - I wish to participate in the dependent care account (Please place election to the right) ☐ **NO** - I decline to participate in the dependent care account	Annual election amount $

Section 4 - Pre-tax premium elections

On a separate enrollment form, I have enrolled in one or more healthcare coverages (medical, dental, vision) and I have received materials showing my share of the contributions for such coverage. I understand that an amount equal to such contributions will be deducted on a pre-tax basis from my paychecks to pay for the coverages that I elected. I understand that my contributions to premium may be automatically increased or decreased to coincide with changes made to my coverage premium(s).

continued >

Section 5 - Employee certification

Read this section carefully then sign and date the form.
Make or keep a copy for your records and submit the completed form to your payroll, personnel or benefits office.

As evidenced by the signature below:

- I certify that I will not seek reimbursement elsewhere for expenses that the health care FSA reimburses automatically. Or, if I have been automatically reimbursed for any amount that has also been paid or reimbursed by another health plan, I will notify Priority Health and arrange to repay that amount to my health care FSA. I understand that if Priority Health is aware that I have health care coverage under more than one plan, or if I'm on a Limited Flexible Spending account, this health care FSA will not reimburse me automatically for my expenses and I am responsible for submitting claims for any unreimbursed expenses to this health care FSA by mail or fax. This will give me the opportunity to submit my unreimbursed expenses to my other health care coverage(s) for possible payment prior to seeking payment from my health care FSA.
- I understand any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws.
- I understand that the deduction(s) listed above will be in effect for the plan year and cannot be revoked or changed unless I experience a change in my family status or termination of my spouse's employment, consistent with federal regulations.

Employee signature_______________________________ Date_______________________

Section 6 - Changes (employer use only)

Indicate any changes in family status such as marriage, birth or adoption, or divorce.

Change in status	REASON FOR ADDITIONS OR CHANGES ☐ MARRIAGE ☐ BIRTH ☐ CHILD BY LEGAL ADOPTION/GUARDIANSHIP (ATTACH COPY OF COURT FORM) ☐ OTHER ____________		EFFECTIVE DATE OF CHANGE / /
	REASON FOR DELETIONS OR CHANGES ☐ MARRIAGE OF DEPENDENT ☐ DIVORCE ☐ DEATH ☐ LOST ELIGIBILITY ☐ OTHER ________		EFFECTIVE DATE OF CHANGE / /
Election change	Health care account	OLD ANNUAL ELECTION AMOUNT $	NEW ANNUAL ELECTION AMOUNT $
	Dependent care account	OLD ANNUAL ELECTION AMOUNT $	NEW ANNUAL ELECTION AMOUNT $

Employer signature _______________________________ Date_______________________

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history or any requests for or receipt of genetic services.