Meritain Health
an aetna company

Mohave County

FSA Enrollment Form

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI

EMPLOYEE SOCIAL SECURITY NUMBER	GENDER	DATE OF BIRTH
	☐ M ☐ F	

HOME ADDRESS	EMAIL ADDRESS

CITY	STATE	ZIP CODE

HOME TELEPHONE	WORK TELEPHONE	I GIVE THE FSA TEAM PERMISSION TO RELEASE INFORMATION ABOUT MY FSA TO MY SPOUSE. ☐ YES ☐ NO

BENEFIT ADMINISTRATOR SECTION

PLAN YEAR	GROUP #
01/01/2025-12/31/2025	13862

EFFECTIVE DATE	DIVISION #
	☐ G01 - EPO ☐ H01 - HDHP

DATE OF HIRE

PAY CYCLE

☐ WEEKLY ☐ MONTHLY
☒ BI-WEEKLY ☐ SEMI-MONTHLY
☐ OTHER: _____

ELIGIBLE DEPENDENTS – INFORMATION IS REQUIRED (Lawful spouse and/or your child(ren) under age 26 you will use this benefit for)

Dependent's Name (Last, First, MI)	Gender	Relationship	Birth Date	Social Security Number
	☐ M ☐ F	Spouse		
	☐ M ☐ F	Child		
	☐ M ☐ F	Child		
	☐ M ☐ F	Child		

Please check all that apply:

☐ HEALTH CARE ACCOUNT (Check box and complete for yourself/dependent expenses ONLY)

I would like to contribute $_____ per pay period ($_____ annually) to my Health Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $3,300 per calendar year. MAX allowed per pay period (26 pays):$126.92

☐ DEPENDENT CARE ACCOUNT (Check box and complete for eligible day care type expenses ONLY)

I would like to contribute $_____ per pay period ($_____ annually) to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $5,000 per family or $2,500 per individual (or spouse when married and filing separate tax returns) MAX allowed per pay period (26 pays): Family - $192.31 or Individual - $96.15

EMPLOYEE SIGNATURE REQUIRED

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

EMPLOYEE SIGNATURE	DATE