The Federal FSA Program

Absentee Enrollment

Enrollment Form

Name:	**SSN:**
Address:	**City/State/Zip:**
Email Address:	**DOB:**
Agency:	**Payroll:**

Absentee Enrollments will be accepted if you were unable to enroll during the Open Season for reasons outside of your control. If you wish to make a belated enrollment due to extenuating circumstances, you will need to complete the enrollment form within 30 days of return to your duty station, but no later than October 1 of any Plan Year. Since all FSA elections must be made prospectively, the belated enrollment is effective the day after your election has been submitted to SHPS and cannot be changed unless you experience a Qualified Status Change. Claims for services rendered prior to the enrollment effective date will not be paid.

Check applicable box(es) to indicate the event that applies to your absentee enrollment and indicate the day you returned to your duty station.

☐ On TDY during Open Season

☐ Out of the country during Open Season

☐ On Leave Without Pay (LWOP) during Open Season

☐ Personal situation (e.g. hospital, illness) that prevented enrollment during Open Season

☐ Other (please explain) ____

Date of return to duty station ___________

❒ **Health Care Flexible Spending Account**
If you wish to enroll in the Health Care Flexible Spending Account, please indicate the amount you wish to contribute for the 2004 Plan Year. The maximum allowable annual election is $4,000 and the minimum is $250. By law, any amounts remaining in your Health Care Flexible Spending Account after the end of the Plan Year, for which valid expenses have not been incurred, will be forfeited.

I wish to contribute $_______________ for the year 2004.

❒ **Dependent Care Flexible Spending Account**
If you wish to enroll in the Dependent Care Flexible Spending Account, please indicate the amount you wish to contribute for the 2004 Plan Year. The maximum allowable annual election is $5,000 (if married and filing taxes separately, the maximum is $2,500) and the minimum is $250. By law, any amounts remaining in your Dependent Care Flexible Spending Account after the end of the Plan Year, for which valid expenses have not been incurred, will be forfeited.

I wish to contribute $_______________ for the year 2004.

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❒ **Please read the following carefully before you make your elections:**

- I agree that my compensation will be reduced by the amount I have elected under the Federal FSA Program, continuing for each pay period until this agreement is amended or terminated.
- I understand that I cannot change or revoke any of these elections as of any date prior to January 1, 2005, unless I experience a Qualified Status Change (e.g., marriage, divorce, birth or adoption of a child, death of a spouse or child, termination or commencement of employment by my spouse and other such events allowed under the Internal Revenue Code) and the election change is caused by, and consistent with, the Qualified Status Change.
- I understand that any pre-tax elections I have made will reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be slightly decreased.
- I understand that prior to the anniversary date (January 1) each year I will be offered the opportunity to add, change or reduce my elections for the following Plan Year. If I wish to continue in one or both of the Flexible Spending Accounts during the FEHB/FSA Open Season, I must make an election each year or it will automatically stop.
- I understand that my allotment per pay date is my election divided by the number of remaining pay dates in the Plan Year 2004, unless I have indicated that I want to have the allotments taken at an accelerated rate. If I experience a period in which allotments are not taken from my pay due to a leave without pay, transfer, etc., upon my return I understand that allotments will resume and will be accelerated to meet my annual election.
- I understand that I can only submit claims for reimbursement of eligible expenses for the 2004 Plan Year that are incurred on or after my effective date through December 31, 2004 and that any amounts remaining in my Health Care Flexible Spending Account and/or my Dependent Care Flexible Spending Account after the end of the Plan Year, for which valid claims have not been incurred, will be forfeited and that my agency does not have the authority to provide waivers for myself or any employee regarding funds that may be forfeited.
- I understand that I must file all claims for the Plan Year no later than 120 days after the end of the Plan Year, December 31.

❒ After you have determined your allotment amounts, you can enroll by:
1) Calling the FSAFEDS Line at 1-877-FSAFEDS (372-3337)
2) Faxing your enrollment form to 1-502-267-2233

If you are enrolling via the FSAFEDS Line, please keep this form for your records. You do not need to return this form to SHPS unless it is the only way you are enrolling for an FSA.

I have read and agree to the terms of participation set forth on this form.

____________________________________ ________________
Signature Date