HealthEquity

Flexible Spending Account
Employee Enrollment Form **Employer Name** _____

Personal Information

Primary Subscriber information

First Name: _____ Middle Initial: ___ Last Name: _____

Social Security Number: _____ Gender: ☐ M ☐ F Date of Birth: _____

Email *(used for HealthEquity communications)*: _____ Contact Phone: (____) _____

Spouse Information (if spouse card desired for health care reimbursement account)

First Name: _____ Middle Initial: ___ Last Name: _____

Social Security Number: _____ Gender: ☐ M ☐ F Date of Birth: _____

Address Information

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Insurance Coverage Effective Date _____ Coverage Type: ☐ Single ☐ Family

Annual Elections

Plan Type	Contribution Per Pay Period	# of Pay Periods	Annual Election Amount	Not To Exceed
Dependent Care Reimbursement Account		24		$5,000
General Health Care Reimbursement Account		24		$2,500
Limited Purpose Health Care Reimbursement Account		24		$2,500
Employer Contributions Only (HDHP participants only)		24		$332.16

- Combined employer and employee contribution cannot exceed $2,500 for general and limited purpose health care reimbursement accounts for HDHP participants

Signature

_____ _____ _____

Print Name Signature Date