Stetson University

FLEX SPENDING ENROLLMENT FORM

2020 Plan Year Enrollment Form

Employee ID	Last Name	First Name and MI	Social Security #
Employment Date	Effective Date	Office Phone	Location
	01/01/2020		

To add family members, complete this area:

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		

Indicate the benefits you wish to pay through tax-free salary reduction by checking the appropriate boxes and entering the necessary information below. Calculate contributions carefully as unused funds exceeding $500 are forfeited at the end of the plan year.

	FLEX Reimbursement Account	Annual Amount	Pay Period Amount
Pay Frequency: ☐ Bi-weekly (24) ☐ Monthly (12) ☐ 9-month (9)			
☐	**Medical Expense** – Indicate the amount you wish to contribute. Medical expenses are **limited to $2,700**. Annual amount divided by pay frequency i.e., 24 if paid bi-weekly. If enrolling mid-year, then divide annual amount by remaining pay cycles in the calendar year.	$ _________	$ _________
☐	**Dependent Care Expense** – Indicate the amount you wish to contribute. Dependent care expenses are **limited to $5,000 ($2,500 if you are married and file separate returns)**. Annual amount divided by pay frequency i.e., 24 if paid bi-weekly. If enrolling mid-year, then divide annual amount by remaining pay cycles in the calendar year.	$ _________	$ _________

IMPORTANT

- I understand that this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I understand that my Group Medical Premiums will be paid automatically through tax-free salary reduction unless waived.
- I hereby authorize my employer to reduce my gross salary before federal, state, and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved Family Status Change.
- I understand that any amount remaining **in excess of $500** in any Flex Reimbursement Account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year.
- I understand I must enroll every year.

Employee Signature	Date

Submitting claims to Wage Works: send all flexible benefits claims to Take Care by WageWorks, PO Box 14054, Lexington KY, 40512

Email: claims@takecareclaims.com Fax: 877-782-8889

Stetson University
FLEX SPENDING ENROLLMENT FORM
2020 Plan Year Enrollment Form

WAGEWORKS

Follow these helpful tips for completing your Request for Reimbursement:

Please be sure to complete all required sections to ensure quick processing of your request. All fields must be filled in completely; **do not include "See Attached" in any field.**

- Do not submit Dependent Day Care (DDC) or Unreimbursed Medical (URM) claims **until after services are rendered.**
- Attach a legible receipt (or receipts) from the service provider showing:
  - A description of the service, or list of supplies furnished
  - The charge(s) for each service
  - The date(s) of each service
  - The name of person(s) receiving service
  - Note: Drug recipients must show the drug name. Balance due statements and credit card receipts are not valid unless they indicate all of the listed above required information. All receipts should be accompanied by a Request for Reimbursement form.
- Remember that the service provider's signature on the Request for Reimbursement can be substituted for a receipt.
- If you carry group insurance, submit expenses to the insurance carrier first. Attach the Explanation of Benefits (EOB) to document reimbursement or to credit your deductible and coinsurance amounts.
- Note that checks will not be written for less than $15. Requests for less than $15 will be applied to future requests.

Submitting claims to WageWorks

Send all flexible benefits claims to WageWorks:

Email: claims@takecareclaims.com
Fax: 877-782-8889
Mail: take care by WageWorks
P.O. Box 14054
Lexington, KY 40512