

Federal FSA Program

Belated Enrollment Form



FSAFEDS will accept your Belated Enrollment if you were unable to enroll during the Open Season for reasons outside of your control. If accepted, your enrollment will be effective January 1, or the day after FSAFEDS receives your form, whichever is later. Your expense must be incurred on or after the date your enrollment/election is effective to be eligible for reimbursement under FSAFEDS.

Name:	SSN:	DOB:
Address:	City/State/Zip:	
Primary Email Address:	Daytime Phone:	
Agency:	Payroll Office Identification (POI) – DOD Only**:	
FEHB Plan:	UserID: (required for account access; must be 6-9 characters; no symbols (\$, #, -, etc.)	

**If you are employed by an Agency under Department of Defense, you must provide the POI number found on the bottom of your Leave and Earnings Statement.

Electronic Funds Transfer (EFT) Information - EFT is required to enroll in FSAFEDS

Bank Name:	Account Type: (savings or checking)
ABA/Bank Routing Number:	Bank Account Number:

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

- | | |
|---|---|
| <input type="checkbox"/> Out of the country during Open Season | <input type="checkbox"/> Personal situation (e.g. hospital, illness) that prevented enrollment during Open Season |
| <input type="checkbox"/> On a period of Leave Without Pay (LWOP) throughout Open Season | <input type="checkbox"/> Other (please explain) _____ |
- Date of return to duty station** _____

Dependent Care Flexible Spending Account (DCFSA)

Please indicate the amount you want to contribute for the 2007 Benefit Period. 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 DCFSA after the end of the Benefit Period, for which valid expenses have not been incurred, will be forfeited. The Federal maximum per household is \$5,000.

- I wish to contribute \$_____ for the 2007 Benefit Period.
 I do not wish to contribute to a dependent care account for the 2007 Benefit Period.

Health Care Flexible Spending Account (Select the appropriate box below)

- Health Care Flexible Spending Account (HCFSA)
 Limited Expense Health Care Flexible Spending Account (LEX HCFSA)

Please indicate the amount you want to contribute for the 2007 Benefit Period. The maximum allowable annual election is \$5,000 and the minimum is \$250. By law, any amounts remaining in your HCFSA or LEX HCFSA after the end of the Benefit Period, for which valid expenses have not been incurred, will be forfeited.

- I wish to contribute \$_____ for the 2007 Benefit Period.
 I do not wish to contribute to a health care account for the 2007 Benefit Period.
 I wish to enroll in the Paperless Reimbursement program if my FEHB plan participates.

Please note: Paperless Reimbursement is for HCFSA only. Please select your plan from the list on page 2.

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The Federal FSA Program

Below is a list of currently participating FEHB plans in the paperless reimbursement program. Please check one.

American Postal Workers Union Health Plan	<input type="checkbox"/>	M.D. IPA	<input type="checkbox"/>
Association Benefit Plan	<input type="checkbox"/>	Mail Handlers/First Health	<input type="checkbox"/>
BCBS Service Benefit Plan	<input type="checkbox"/>	National Association of Letter Carriers Benefit Plan	<input type="checkbox"/>
Foreign Service Benefit Plan	<input type="checkbox"/>	Preferred Care	<input type="checkbox"/>
Government Employee Hospital Association	<input type="checkbox"/>	Special Agents Mutual Benefit Association	<input type="checkbox"/>
Humana	<input type="checkbox"/>		

In order to participate in Paperless Reimbursement, the FEHB Contract Holder's Social Security Number must be on file with your FEHB plan. This information is only used to validate your FSAFEDS account and to ensure proper reimbursement. If you are not the FEHB Contract Holder, you must provide FSAFEDS with the Contract Holder's necessary information. If you are not the FEHB Contract Holder please provide the following information:

Contract Holder Name: Contract Holder SSN:

Submitting your Belated Enrollment to FSAFEDS

After making your elections:

1. Read, sign and date the form below.
2. Forward both pages of this form to FSAFEDS via fax or mail.
 - Fax: 1-866-643-2245 (toll-free) or 1-502-267-2233
 - Mail: FSAFEDS Program • PO Box 36880 • Louisville, KY 40232

Please read the following carefully before you make your elections.

By accepting below, I acknowledge I understand that:

My salary will be reduced by the amount I have elected under the Federal FSA Program, known as FSAFEDS, continuing for each pay date until this agreement is amended or terminated. My salary reduction automatically terminates after the last pay date in the 2007 calendar year. These reductions do NOT automatically carry forward for the following calendar year.

I agree to use Electronic Funds Transfer (EFT) for my reimbursements.

Please note: If you do not use the services of some type of financial institution and/or your financial institution is not capable of receiving Electronic Funds Transfers (EFT), you cannot enroll in the FSAFEDS Program. Please contact an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), (TTY: 1-800-952-0450), Monday through Friday, 9:00 A.M. until 9:00 P.M., Eastern Time for additional information.

I must make an election to participate for the 2007 Benefit Period.

I cannot change or revoke any of my elections:

- Until the next Open Season, when I can make a new election.
- Unless I experience a [Qualifying Life Event](#) (for example, marriage, divorce and other such events allowed under the Internal Revenue Code and this Plan) and my election change is caused by, and consistent with, the Qualifying Life Event. If my Qualifying Life Event occurs after October 1, I will be limited to a decrease in my election amount.

I have to make a new election to participate for the next Benefit Period. If I do not make a new election, I will NOT be participating for the next Benefit Period.

My allotments for FSAFEDS are pre-tax elections and will reduce my salary for Social Security tax purposes. This means that my Social Security benefits could be slightly decreased.

If I wish to continue my enrollment, I must make an election each year during the FSAFEDS Open Season, or my enrollment will automatically stop.

My allotment per pay date is my annual election divided by the number of remaining pay dates in the 2007 Benefit Period.

I understand that I can only submit claims for reimbursement of eligible expenses for the 2007 Benefit Period that are incurred on or after my effective date as shown on my confirmation statement, through March 15, 2008.

I will forfeit any amounts I have remaining in my 2007 health care and/or dependent care account(s) after March 15, 2008, for which I have not incurred valid expenses and submitted valid claims. My agency does not have the authority to provide waivers for me or any employee regarding funds that may be forfeited.

I must file all claims for the 2007 Benefit Period no later than April 30, 2008.

Signature _____
Date

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