FLEXIBLE SPENDING ENROLLMENT

☐ New enrollment ☐ Mid-year change ☐ Open enrollment

A. PARTICIPANT INFORMATION (REQUIRED–COMPLETE IN FULL)

EMPLOYEE NAME	DMBA ID NUMBER
EMPLOYER NAME	EMAIL

B. FLEXIBLE SPENDING ELECTIONS

☐ HEALTHCARE ACCOUNT

Total Annual Election $

Annual maximum = **$3,200**

☐ DEPENDENT CARE ACCOUNT

Total Annual election $

Annual maximum: Married, filing separately = **$2,500** a year.
Others = **$5,000** a year. Cannot be more than your earned income or your spouse's earned income, whichever is less.

C. MID-YEAR CHANGE IN FAMILY STATUS (PLEASE EXPLAIN)

☐ Change in marital status: _____

☐ Change in dependent status: _____

☐ Change in work status: _____

Date of change in family status: _____

D. HEALTHCARE FSA BENEFIT CARD

☐ **I WANT TO RECEIVE A HEALTHCARE FSA BENEFIT CARD**: I understand that by receiving a card, I may be required to "substantiate" (or verify) my eligible purchases by submitting itemized receipts to DMBA.

☐ **I DO NOT WANT A HEALTHCARE FSA BENEFIT CARD**: I understand by declining the card, I may only choose to receive one during the next open enrollment.

E. PARTICIPANT AUTHORIZATION (REQUIRED)

I choose to be reimbursed from my Flexible Spending Account(s) for qualified expenses according to plan guidelines for claims submission. I understand the total annual elections indicated above will be withheld in equal increments from each paycheck throughout the plan year. If my total annual election exceeds my actual substantiated expenses, I understand I forfeit the excess to my employer. I release my employer from all present and future rights or claims to any sums reduced from my paycheck and used for payment of expenses through my Flexible Spending Account(s). I understand my total annual election amount and my participation during the plan year may only be changed because of a change in family status. I understand mid-year changes to my Flexible Spending Account(s) must be consistent with my change in family status and must be made within 60 days of the change. I understand I may not decrease my election to less than the amount already in my account(s). I accept responsibility for proper income tax reporting in regard to benefits reimbursed by this plan.

Signature: _____ Date: _____

Please return this completed form to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530. You may also email it to enrollmenthelp@dmba.com or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.