



FlexSystem Employee Enrollment Form

Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected.

Return the completed and signed form to your employer for processing.

For Employer to complete:

Employer Name: _____ Client TASC ID Number _____
Participant Plan Effective Date: **JULY 1, 2024** Date of First Payroll _____

EMPLOYEE/PARTICIPANT INFORMATION

Last Name _____ First Name _____ Middle Initial _____
TASC ID# (if known) _____ Email Address* _____
Home Phone Number* _____ Mobile Phone Number* _____

Home Address (street) _____
City _____ State _____ Zip Code _____

**Required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.*

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

I request the following amount(s) to be deducted pre-tax:		Employee Annual Salary Reduction Election Amount	IRS Contribution Limits (2024)
1	Healthcare FSA	\$ _____	\$3200 per year
2	Dependent Care FSA (daycare)	\$ _____	\$5000 per year; \$2500 if married filing single
3	Transit Account	\$ _____	\$315 per month

TASC CARD

You will receive one TASC Card for your FlexSystem account. You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed in FlexSystem.

To request an additional TASC Card for your spouse or dependent, please call TASC Directly at 1-800-422-4661. If you are a new participant please call after you have received your TASC Card.

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire Plan Year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature _____ Date _____



ENROLLMENT FORM INSTRUCTIONS

Enter your Client ID and Employer name in the space indicated. Refer to your employer for the correct Client TASC ID number and Employer name.

Instructions for entering elections under each applicable FlexSystem account type:

- 1. Healthcare FSA Election:** This amount you expect to pay out- of- pocket toward eligible medical expenses throughout the Plan Year, which may include deductible and co- insurance portions of health insurance (NOT premiums), dental expenses, orthodontic expenses, eye care, and other eligible healthcare expenses. Per IRS regulations, a Participant may elect a maximum based on the current IRS limits. Your employer may have a Plan Year maximum less than the IRS allowed amount. Review your Summary Plan Description (SPD) or check with your employer for your Plan's maximum annual amount. Your annual election will be split into equal amounts to be deducted pre- tax from every payroll throughout the Plan Year. Your total annual election amount is available for reimbursement on the first day of the Plan Year as eligible expenses are incurred.
- 2. Limited Purpose FSA Election:** The same as the FSA Election above **EXCEPT** eligible expenses are limited to "non-Medical" and include Dental and Vision expenses **ONLY**. This election is for individuals who are enrolled in the **High Deductible Health Plan AND HSA**.
- 3. Dependent Care FSA Election:** Amount you expect to pay out- of- pocket for eligible day care expenses for the Plan Year. Your annual contribution must be within the maximum allowable amount under IRS regulations for a family or for married individuals filing single. Plan funds are available as they are contributed.

IMPORTANT NOTES

Helpful Links

Find all IRS limits on our resource web page: <https://www.tasconline.com/benefits- limits/>