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866-451-3399

Flexible Spending Account (FSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. **This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.**

*=Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

Employee ID Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

*City

*State

*Zip

Email Address

Day Telephone

*Date of Birth (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Gender (M/F)

*Marital Status (Married/Single)

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. **Note:** Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Plan Type (If enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer.)	Medical FSA Limit set by employer	Dependent Care Account Limit set by employer up to IRS maximum	Limited FSA Limit set by employer if this plan type is offered
*Annual Election (if employer funded, note "ER" next to amount):	$	$	$
*Number of Pay Periods (if enrolling mid-year, please enter the number of remaining pay periods within the plan year):	÷	÷	÷
*Per Pay Period Amount (to be deducted each pay period):	=	=	=
*Date of First Payroll (mm/dd/yyyy):			
*Participant Effective Date (mm/dd/yyyy):			

*Pay Frequency (please check one):

Monthly | Semi-Monthly | Bi-Weekly 24 | Bi-Weekly 26 | Weekly | Other

Step 4: Authorization

I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

*Participant Signature

*Date

Step 5: Refusal (**Note:** Only complete this step if you are NOT electing to enroll in a Flexible Spending Account)

Participant Signature

Date