Flexible Spending Account (FSA) Enrollment Form

M&T Insurance Agency, Inc.

Employer Name: Daemen College **Employer Code:** mti3205

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Annual Elections (Contribution on Per Pay Period x Number of Pay Periods = Your Annual Election on Amount)

	Contribution on Per Pay Period	Pay Periods Remaining		Annual Election
Flexible Spending Account (FSA)	$	X	=	$
Dependent Care Flexible Spending Account (DCA)	$	X	=	$

Eligible Dependent Information:

Name	SSN	Date of Birth	Relationship	Addt'l Card (if over 18)

Employer Use Only

Insurance Coverage:

Health Plan ID:	Coverage Effective Date: (mm/dd/yyyy)	Coverage Type ☐Single ☐Two-Person ☐Family

Enrollment Information:

Date of Hire: (mm/dd/yyyy)	Employee ID:	Effective Date: (mm/dd/yyyy)
Enrollment Type	☐ Initial Enrollment ☐ New Plan Year ☐ Mid-Year Change ☐ Termination	

I acknowledge that I have received, read, and understand the material which explains my FSA Plan and my options under it. I understand that any expenses paid under this Plan must be for eligible expenses as allowed under the Plan and governed by IRS regulations. I further understand that expenses eligible for reimbursement must be for services provided for me or a qualifying individual as defined under the Plan while covered under the Plan, and that the expenses must not be reimbursed from any other source, including insurance. I also understand that my above election cannot be modified or changed within the plan year unless I have experienced a correlating Qualifying Event and notify my employer within 30 days of such event.

Signature ☐ I decline to participate in the FSA plan.

Print Name	Signature	Date