SelectAccount®

DIOCESE OF CROOKSTON, INCORPORATED
FLEXIBLE SPENDING ACCOUNT
ENROLLMENT FORM

(VII) EMPLOYER/EMPLOYEE INFORMATION

Employer Number: 000693 Plan Year: 9/1/2014 through 8/31/2015

Effective Date: _____ (To Be Provided by Group Contact)

Location (if applicable):_____

Employee Social Security Number: _____

Employee Name: _____
(Last, First, MI)

Home Address: _____
□ Check here if address should be updated
_____, _____ _____
(City) (State) (Zip)

Work Phone Number: (____) _____ Date of Birth _____

Email Address: _____

(VIII) ELECTIONS

Medical Flexible Spending Account
Plan Year Maximum of $ 2500

[ ] I want to contribute a total of $ _____ during this Plan Year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

Important Notice: If you establish an HSA, your medical FSA is a limited FSA and can only reimburse dental and vision expenses.

Dependent Care Flexible Spending Account - for dependent child care and/or elder care
Plan Year Maximum of $ 5,000 ($2,500 if married but filing separate tax returns)

[ ] I want to contribute a total of $ _____ during this Plan Year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

(IX) SIGNATURE

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited.

_____ _____
Signature Date

P.O. Box 64193 St. Paul, MN 55164-0193
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MII Life, Inc. d.b.a. SelectAccount