Reset Form

Flexible Benefits Election Form

EMPLOYER NAME: City of West Des Moines

❑ Health Care Flex Plan: 7/1/19 - 6/30/20
❑ Limited Purpose FSA (Dental/Vision Only): 7/1/19 - 6/30/20

Last Name:		First Name:	Date of Birth:
Address:		City:	State: Zip:
☐ Single ☐ Married	☐ Male ☐ Female	Phone Number:	SSN (not required if currently enrolled:
Email Address:			

You must choose to elect or decline for each program.

EMPLOYEE CONTRIBUTION - HEALTHCARE FLEXIBLE SPENDING PROGRAM

☐ I elect to participate in the Healthcare Flexible Spending Program. I direct and authorize my employer to reduce my annual salary for the above plan year and deposit this amount into my Healthcare Flexible Spending Account**:**

26 (No. of Pay Periods) X _____ (Payroll Deduction) = _____ (Annual Amount)

EMPLOYER CONTRIBUTION (WELLNESS PLAN ONLY) - HEALTHCARE FLEXIBLE SPENDING PROGRAM

☐ I am eligible to receive Flexible Spending from the City of West Des Moines because I am enrolled in the Wellness Plan and participated in the Annual Wellness Screening.

I authorize my employer to deposit this amount into my Healthcare FSA**:** _____

Direct Deposit Authorization

If you are new to enrolling in the flex plan and are interested in signing up for direct deposit, please log in to the consumer portal **https://kabelparticipant.lh1ondemand.com** after the start of the new plan year. If you have already provided Kabel with direct deposit information in the past, there will be nothing further needed and we will continue to send your reimbursements as direct deposit. You can also update your banking information in the consumer portal. The City of West Des Moines will not be able to update this information.

EMPLOYEE AUTHORIZATION

I have read all the enrollment literature explaining these benefits. I understand that any contributions to the account can only be used to reimburse eligible expenses under the account and that I forfeit any funds remaining in my account at the end of the plan year after all claims have been filed. I further understand that I may not change my contributions during the plan year unless I have a Qualifying Event. Furthermore, my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll deductions as contributions to my Healthcare Flexible Spending Program as indicated above.

Employee's Signature: _____ Date: _____

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