FLORES

FSA*Direct* ENROLLMENT FORM

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS.

GENERAL INFORMATION

Group: Town of Chapel Hill Plan ID: 1000842359

ID#

	Last	First
Name		

Address

City State Zip –

Phone ( ) – – E-Mail

Pay Frequency ○ Weekly ◉ Bi-Weekly ○ Semi-Monthly ○ Monthly Effective Date

All enrollment elections made on this form are effective for the plan year beginning 09/01/25 and ending 08/31/26. No changes can be made to these elections once the plan year has begun unless you experience a family status change event. See your enrollment booklet for a list of these events. **Return the completed form to your Human Resources department.**

For Assistance Call 1-800-532-3327

MEDICAL SPENDING ACCOUNT INFORMATION

Minimum Annual Contribution: $300.00 Maximum Annual Contribution: $3,300.00

In the spaces provided below, indicate the amount you wish to contribute to the Medical Spending Account for the year and the amount to be deducted from each paycheck. Note: If your annual election does not equal your paycheck deduction multiplied by the number of payperiods left in the plan year, then your paycheck deduction amount will be adjusted accordingly.

Your Annual Election: Your Paycheck Deduction:

DEPENDENT CARE SPENDING ACCOUNT INFORMATION

Minimum Annual Contribution: $300.00 Maximum Annual Contribution: $5,000.00

In the spaces provided below, indicate the amount you wish to contribute to the Dependent Care Spending Account for the year and the amount to be deducted from each paycheck. Note: If your annual election does not equal your paycheck deduction multiplied by the number of payperiods left in the plan year, then your paycheck deduction amount will be adjusted accordingly.

Your Annual Election: Your Paycheck Deduction:

INSURANCE PREMIUM INFORMATION

In the spaces provided below, indicate the amount to be withheld from your paycheck for each listed insurance plan. If you are not participating in a plan, enter zero as your deduction amount for that plan. Lines labeled "Not Applicable" should be left blank.

Group Health P			
Dental Policy			
FSA Contributi			
Cancer Insuran			

PAYROLL AUTHORIZATION

I have read The Summary Plan Description provided by the above mentioned employer and hereby choose to participate as shown above. I agree to a per pay period reduction during the plan year referenced above for the amounts indicated. I understand that this election is binding for the plan year and that changes are only permitted in case of a change in family status or spouse's employment.

Employee Signature (Void if not signed) Date