FBMC

Fringe Benefits Management Company

State of Washington Enrollment Form

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Medical Expense Flexible Spending Account.

Press hard with ballpoint pen.

Name (Please Print) Last	First	MI	Social Security #

Home Address Street	City	State	Zip

Daytime Phone ( )	Home Phone ( )	Date of Hire	Date of Birth	Annual Salary

ENROLLMENT STATUS: ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ NEW HIRE — Effective Date

Number of Months Paid: 9 ☐ 10 ☐ 11 ☐ 12 ☐

Indicate the amount you wish to pay through tax-free salary deduction by completing the section below.
Complete the worksheets provided in your Flexible Spending Account (FSA) packet before deciding on the amount.
If you have questions, consult your FSA packet or call FBMC Customer Service at 1-800-342-8017.

In Box #1 indicate the dollar amount you elect to contribute for the Plan Year, which is January 1, 2004 through December 31, 2004.
In Box #2 indicate the number of regular payroll checks with deductions you expect to receive during the Plan Year.
In Box #3 indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding).
By signing this form you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement, or any other anticipated leave.

MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT

For uninsured eligible medical expenses incurred by you, your family members, or both.
[Maximum allowable contribution is $2,400; Minimum is $240]

Box #1
Total Plan Year Dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected _____

Box #3
Reduction Per Regular Paycheck _____

EMPLOYER

Please check the box by your employer name:

- ☐ 695 - Bates Technical College
- ☐ 627 - Bellevue Community College
- ☐ 629 - Big Bend Community College
- ☐ 634 - Cascadia Community College
- ☐ 375 - Central Washington University*
- ☐ 635 - Clark College
- ☐ 610 - Edmonds Community College
- ☐ 605 - Everett Community College
- ☐ 376 - Evergreen State College
- ☐ 648 - Grays Harbor College
- ☐ 652 - Highline Community College
- ☐ 692 - Lake Washington Technical College
- ☐ 657 - Lower Columbia College
- ☐ 662 - Olympic College
- ☐ 665 - Peninsula College
- ☐ 637 - Pierce College
- ☐ 670 - Seattle Community College
- ☐ 672 - Shoreline Community College
- ☐ 352 - State Board for C & TC
- ☐ 678 - Tacoma Community College
- ☐ 360 - University of Washington
- ☐ 683 - Walla Walla Community College
- ☐ 365 - Washington State University*
- ☐ 380 - Western Washington University*

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved Change In Status with the contract administrator within 60 days of the event or before the end of the plan year.
- I understand and agree that my employer and FBMC, the contract administrator, will not incur, and I specifically release from them, any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law. Fla. Stat. Ch. 817.234(1)(b)(2001).

Please send this signed form to the attention of Enrollment Processing, P.O. Box 1878 Tallahassee, FL 32302-1878.

* If employed by these Universities - please send form to your Benefit Office.

Employee Signature	Date Signed

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES