BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
www.bbpadmin.com
630 773 2337

Employer Name: _____

Flexible Spending Account Enrollment Form - Benefit Plan Year

This form must be completed & given to HR/Payroll by

Employee Name: _____

New enrollees only – *Please complete **all** fields. In order to add your eligible dependents, please login to your account at* https://betterbusinessplanning.wealthcareportal.com *after you receive your welcome letter with your login instructions.*
Current participants only – *Please login to your account at* https://betterbusinessplanning.wealthcareportal.com *to make any updates to your account information below or to add eligible dependents to your account.*

Employee Address: (Address, City, State, Zip) _____

Social Security Number: _____ Date of Birth: _____

E-Mail Address: _____ Telephone: _____

	Annual Election	# of Pay Periods	Per Paycheck
☐ FSA Medical	$ _____	÷ _____	= _____
☐ FSA Medical Limited Purpose* *(Only Choose FSA Limited Purpose if enrolled In another medical pre-tax program.)*	($3,050 Annual Maximum)		
☐ FSA DCAP / Day-Care Reimbursement** *(Your spouse has to be working or actively looking for work in order to be enrolled in the FSA DCAP)*	$ _____	÷ _____	= _____
	($5,000 Annual Maximum - If head of household or married and file a joint return)		
	($2,500 Annual Maximum – If married and file a separate return)		

DIRECT DEPOSIT INFORMATION (if available to your group). To expedite your payment, please login to https://betterbusinessplanning.wealthcareportal.com to provide/update your direct deposit information. (There is a $25 fee to reissue a direct deposit – please refer to one of your checks for your account and routing numbers and NOT a deposit slip)

**My employer might have the FSA Medical plan continue past my termination. If so, the paragraph directly below in bold will apply to your plan. Please contact BBP at* support@bbpadmin.com with any questions.

I understand that if I have elected to participate in the medical reimbursement plan and that I must continue in the program through the end of the current plan year even if I terminate employment. My employer will withhold any outstanding pre-tax contributions from my final paycheck, or I will provide post-tax funding to the plan in the event of my termination and agree to either arrangement. In the event of funding the medical reimbursement account with the final paycheck and the paycheck does not cover all remaining contributions; I will be required to make normal monthly post-tax contributions to the Plan in order to continue. Failure to make a normal monthly contribution will result in termination from the plan and collection of remaining funds through a collection agency.

☐ I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's Plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year noted above will be forfeited unless your employer's plan design provides for certain exceptions (e.g., annual grace period or carryover). If the Plan Administrator determines that an expense, I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

By signing this form, I agree to the terms and procedures listed herein.

☐ I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided **NOT TO participate** at this time.

Employee's Signature:_____ Date: _____

BBP Admin
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