

FLEXIBLE SPENDING ACCOUNT

Account number _____

Employee Information

Your name (last, first, middle initial)		Social security number/ID number	
Address (street)			
City		State	ZIP code
Date of birth	Your email address		
<input type="checkbox"/> male <input type="checkbox"/> female			
Spouse's name (domestic partners are not eligible)		Spouse's social security number/ID number	Spouse's date of birth

I want to participate in our Flexible Spending Account (FSA).

Reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand this reduces my wages for social security purposes, and may reduce my social security disability and retirement benefits. I understand I will not earn interest on my contribution. I also understand that once I have made this election, I can only change it during the election period prior to the next plan year, or if there has been a qualifying change in my family status or employment as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time, I terminate participation, or at the end of any plan year, will be forfeited. Because Section 125(b) of the Internal Revenue Code establishes limits on participation in FSA by highly compensated employees and key employees which cannot be determined until the participation of all employees in both contributions and benefits has been tested under the applicable rules, it may be required by law that your salary reduction election amount be reduced, regardless of the terms of your election to participate. Any amount elected in excess of a compliant election amount, must be reported as taxable income.

NOTE: Changes in election allowed due to a qualifying change in the family status must be made no later than 30 days after the date of the qualifying change in the status.

Pay period: (Check the box which indicates the frequency of your paychecks)

weekly
 bi-weekly
 monthly
 twice-monthly
 other _____

Health Care Annual Election* \$ _____	Dependent Care Annual Election* \$ _____	Note: Dependent Care spending accounts are not medical spending accounts for a participant's spouse or children. It's day care (baby-sitting) for children or elderly dependents.
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*The annual election should be based on the number of pay periods remaining.

I want to participate in the Automatic Reimbursement Option.

I am enrolled in the health plan and the Health Care Reimbursement Account. I understand that Health Care Reimbursement payments will not be issued until the reimbursement date. I hereby certify that I do not have other insurance which covers the charges referenced above and will not include them as an itemized income tax deduction.

I decline to participate in our FSA.

I realize that if my election form is not received by the end of the election period, I have declined to participate by default. I understand that I will not be eligible to participate again until the following plan year unless there has been a qualifying change in my family status or employment.

Employee telephone number _____

Signature

Date signed

*Date signed **must** be prior to effective date of the plan year. If change of status occurs during plan year, date signed **must** be prior to pay period in which the above listed contributions will go into effect.

If you would like your reimbursements deposited into your bank account, complete the following information. If you are currently enrolled in the direct deposit option, you do not need to complete a new form, information will roll-over with each renewal.

Your name _____ Social security number/ID number _____

Banking Information **Checking Account Information** or **Savings Account Information**
new set-up* change current set-up* cancel current set-up

Financial institution		City
State	ZIP	
Bank transit / ABA number	Account number	

I hereby authorize Principal Life Insurance Company to credit my FSA Reimbursement in the bank listed above. This authorization is to remain in full force and effect until I send written notice of a change or cancellation.

Signature	Dept/office name	Date
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* Your account will be prenoted for one pay period. The prenote process is done to detect any problems with your bank transit and account numbers. You will receive a regular FSA reimbursement check for the prenote pay period.

Direct Deposit Choices and Information

Your First Deposit and Account Changes

- If you change or close your account(s) complete a new Direct Deposit Authorization form.
- Direct deposit transactions occur on the third business day following reimbursement.

Employer to Complete this Section

Company name as it appears on your billing	Location/unit
Beginning pay period date (Refer to Quick Reference Guide)	Reason for change
	initial request change