Discovery Benefits®
simplify.℠

Flexible Spending Account (FSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. This is an internal document used by your employer for data collection purposes. Worksheets submitted to Discovery Benefits will not be processed.

*= Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

*Employee Identifier Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

Email Address (If provided, all notifications will be sent via email)

*City

*State

*Zip

Day Telephone

*Birth Date (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

Gender (Please circle one): Male / Female

Marital Status (Please circle one): Married / Single

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. *Please Note: Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

***Plan Type** (if enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer)	**Medical FSA** Limit set by employer	**Dependent Care Account** Limit set by employer up to IRS maximum	**Limited FSA** Limit set by employer if this plan type is offered
***Annual Election** (if employer funded, note 'ER' next to amount)	$	$	$
***Number of Pay Periods** (if enrolling mid-year, please enter the number of remaining pay periods within the plan year)	÷	÷	÷
***Per Pay Period Amount** (to be deducted each pay period)	=	=	=
***Date of First Payroll** (mm/dd/yyyy)			
***Participant Effective Date** (mm/dd/yyyy)			
***Pay Frequency** (please circle one)	Monthly / Semi-Monthly / Bi-Weekly 24 / Bi-Weekly 26 / Weekly / Other		

Step 4: Authorization

I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

*Participant Signature

*Date