3816 S Elmwood Avenue, Suite 100
Sioux Falls, SD 57105
Toll-Free: 1 (866) 791-0982
Fax: (605) 322-4688
FlexibleSpending@avera.org
www.AveraHealthPlans.com

Flexible Spending Account Enrollment Form

Plan year (month/year) ___________to____________

Last Name ________________________________ First Name ______________________ Middle Initial _____

Address ____________________________ City ___________________ State ______ ZIP Code ___________

Employer ____

Social Security Number _______________________________________ Date of Hire ____________________

Waiver of Participation I choose not to participate in the Flexible Spending Account at this time. I understand that I will not have another opportunity to enroll during the plan year unless I experience a qualified status change.

Employee Signature ____ Date _________________________

UNREIMBURSED MEDICAL EXPENSE REIMBURSEMENT ACCOUNT

$ ______________________/year which is $ ________________________/paycheck

DEPENDENT CARE EXPENSE REIMBURSEMENT ACCOUNT (FOR DAY CARE EXPENSES)

$ ______________________/year which is $ ________________________/paycheck

I authorize my employer to withhold the above deductions from my paycheck on a pre-tax basis. I understand that the benefit options I have elected will remain in force throughout the plan year, unless I have a qualified change in status.

Employee Signature ____ Date __________________

Direct Deposit I hereby authorize Avera Health Plans to initiate deposits and if necessary, adjustments for any deposits made in error, to the account indicated : Savings *Attach a deposit slip* Checking *Attach a voided check*

Account Number ________________________________ **Transit ABA Routing Number** ___________________

Bank _________________________ **Bank Location** _____________________ **Phone** __________________

How would you like your Flex Explanation of Benefits (EOB) communicated to you?

☐ Mail ☐ E-mail E-mail Address ____

For Employer Use Only

Employer Name ____ Payroll Frequency ___________________

Effective Date __________________ Signature ____________________________ Date ________________

Qualified Change in Status? Effective Date _________________ Reason for Change _______________________

FLX-FORM-010 (10/09)