CAS
Consolidated Admin Services

Cafeteria Plan Enrollment Form

Employee Information (Please print clearly)

Employer Name: **Arkansas Tech University**

First Name _____ MI_____ Last Name _____

Social Security # _____-____-_____ Date of Birth_____/_____/_____ Date of Hire_____/_____/_____

Employee Home Address _____

City _____State _____ Zip Code _____

Email: _____ Contact Phone # _____

Payroll Start Date: _____ _____Bi-Weekly _____Monthly _____10-Pay Period

Benefit Elections

Group Insurance Premiums - *If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a pre-tax basis unless you notify your Human Resource or Personnel Department.*

Flexible Spending Accounts

The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes.

Medical FSA (IRS maximum=$2,700.00) **$** _____ (Annual Amount) **or $** _____ (Per Pay Period)

Limited Medical FSA (Dental/Vision Only with HSA) **$** _____ (Annual Amount) **or $** _____ (Per Pay Period)

Dependent Care (IRS maximum=$5,000.00) **$** _____ (Annual Amount) **or $** _____ (Per Pay Period)

Health Savings Account **$** _____ (Annual Amount) **or $** _____ (Per Pay Period)
(2020 IRS maximum= Single = $3,550.00 / Family = $7,100.00 / 55 catchup = $1,000)

**By participating in a Health Savings Account or Flexible Spending Account you will receive a Benefits Card.*
By using the benefits card, you certify that each time the card is used, it will be used only for Qualified purchases as described in the cardholder agreement, and you have not received or will not see reimbursement for any expenses paid with the card from any other benefit source. This card may not be used at all merchants that accept Visa debit Cards.

Additional Benefits Card Holder Request:

First Name: _____M.I.:____ Last Name: _____ Date of Birth: _____

First Name: _____M.I.:____ Last Name: _____ Date of Birth: _____

Direct Deposit Information / Bank Account Information (NOT REQUIRED)

I authorize Consolidated Admin Services to initiate a credit and/or debit entry to my account for my plan reimbursements. This agreement is to remain in full effect until written notification is supplied by me to CAS terminating this agreement.

Bank Name: _____

Routing Number (always 9 digits): _____ Account Number:_____

A "VOIDED" check must accompany enrollment form. Do not use a deposit slip as the number could be invalid.

Election Information

☐ **Yes**, *I wish to participate in the Health Savings Account or Flexible Spending Account and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.*

☐ **No**, *I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.*

Signature: _____ Date: _____