Flexible Spending Account
Open Enrollment Form

Human Resources must receive form by November 11, 2022

St. Luke's Hospital **Duluth, MN**	**Plan Year:** **2023**	**Effective Date:** **1/1/2023**

EMPLOYEE INFORMATION:

Name: ____ Social Security #:____________________

(Last) (First) (MI)

Address: ____

City: ______________________________ State: _______ ZIP: _________________

FTE: ____________ Date of Birth: ____________________ Phone Number: ____________________

(must be an assigned .6 FTE or above to participate) Email Address: ___________________________________

ELECTIONS:

Medical Care Reimbursement Account*

Plan Year Minimum is $100; Maximum is $2,850 (Do not include your monthly Medical & Dental insurance premiums).

☐ Declined

☐ I want to contribute $______________ in the **Plan Year** to my **Medical Care** Reimbursement Account. I understand this amount will be deducted from my pay in equal amounts throughout the entire Plan Year.

***Those enrolling in the Advantage Plan are NOT eligible for a Medical Flexible Spending Account.**

Daycare Reimbursement Account (for expenses related to daycare, preschool, elder care, etc.)

Plan Year Minimum is $100; Maximum is $5,000 ($2,500 if married but filing separate tax returns)

☐ Declined

☐ I want to contribute $______________ in the **Plan Year** to my **Daycare** Reimbursement Account. I understand this amount will be deducted from my pay in equal amounts throughout the entire Plan Year.

I have reviewed the provisions of the Flexible Spending Account. By emailing this form to EmployeeBenefits@slhduluth.com I authorize the amounts specified above to be deducted from my pay. I also understand the choices indicated will remain in effect for the entire Plan Year unless there is a qualifying event as defined by the IRS. It is my understanding that any monies remaining in my account(s) at the end of the Plan Year will be forfeited.

____ ______________________

Employee Signature Date