AzMT FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

☐ New Election ☐ Election Change PLAN YEAR: 07/01/2023-06/30/2024	
Employee:	SSN:
Mailing Address:	Birth Date:
City/State/ZIP:	Effective Date:

PRE-TAX PREMIUM ELECTION AUTHORIZATION

PAYROLL DEDUCTED PREMIUM BENEFITS elected under IRC Section 125. Payroll deducted premiums will be deducted on a pre-tax basis for the current and all subsequent years based upon this election form until a signed revocation is provided by the participant.

FLEXIBLE SPENDING ACCOUNT ELECTION AUTHORIZATION

The following election choice(s) indicate employee's pre-tax participation in the Flexible Spending Account where offered by employer.

HEALTHCARE SPENDING ACCOUNT: Election must be for qualified expenses that cover only myself, my tax dependents and/or spouse. Cannot exceed annual limit set by employer.

☐ Yes – Annual Amount: $_____ Per Pay Period: $_____
☐ No – I do not wish to participate in the Healthcare Spending Account

DEPENDENT CARE ACCOUNT: Cannot exceed the lower of employee's or spouse's adjusted income. *If one spouse is a full-time student, please inquire about limitations*. Cannot exceed $10,500, or $5,250 if married & filing separately.

☐ Yes – Annual Amount Elected: $_____ Per Pay Period: $_____
☐ No – I do not wish to participate in the Healthcare Spending Account

AUTHORIZATION: *(Please read all before signing)*
With regard to my salary redirection agreement and my election of benefits, I understand that:

1. The dependents for whom I will be claiming medical or dependent care expenses either reside with me in a parent-child relationship or are legally dependent on me for support.
2. I am aware that premium and other contributions made under this plan are the property of my employer and will be used to purchase the elected coverage and cannot be refunded.
3. Reimbursement account claims must be accompanied by documentation of the out-of-pocket expense.
4. I understand that coverage applies only to expenses incurred during participation.
5. I understand this agreement cannot be changed during the plan year unless I experience a qualified status change (e.g., marriage, divorce, birth, adoption, death of spouse or child, change in spouse's employment).
6. I recognize any unused elections will be forfeited at the end of the plan year.
7. This agreement cannot be revoked during the plan year.

Signature: _____ Date: _____

Company Authorization: _____ Date: _____

DECLINATION OF PARTICIPATION: *(Sign only if you are NOT enrolling in the flexible spending plan.)*
My employer's flexible spending plan has been explained to me and I have been given the opportunity to participate and elected not to do so. Signature: _____ Date: _____

DIRECT DEPOSIT FORM

I hereby authorize Arizona Metropolitan Trust to automatically deposit my flexible spending account reimbursements to my bank account. This includes my authorization to reverse any entries made in error. I understand that direct deposit can only be done for checking accounts and not savings accounts. ****This agreement will remain in effect until I give written notice to cancel it.***

Employee Name:_____

Employee Social Security Number:_____

Signature:_____

Date:_____

PLEASE ATTACH A VOIDED CHECK.
WE CANNOT PROCESS YOUR REQUEST WITHOUT IT.

Please Note: A 30-day written notice is required in order to cancel direct deposit.

Please Note: *Your first flex claim will be sent to you by check. Any following flex claims will be by direct deposit. When your flex claim is directly deposited into your account, you will receive an EOB in the mail stating the dollar amount credited to your account and the date the funds were sent.*

Attach a cancelled check here.