YourWay FSA | ONEBRIDGE for your benefit

Flexible Spending Account (FSA) Enrollment Form

To elect to participate in your employer's YourWay FSA benefit, please complete this enrollment form and provide it to your employer's HR contact.

1 EmployerInformation — Employer Use Only

Employer Name:	Employer Number:
Withholding Schedule: ◯ Weekly ◯ Bi-Weekly ◯ Semi-Monthly ◯ Monthly	
Effective Date:	First Withholding Date:
Enrollment Type: ◯ Open Enrollment ◯ New Hire ◯ Re-Enrollment	
Authorized Employer Signature:	

2 Participant Information

Social Security Number:	Date of Birth:	
First Name:	Middle Initial:	Last Name:
Address 1:	Address 2:	
City:	State:	Zip Code:
Phone:		
Email:	☐ Check if you want to receive Plan communications via email.	

FSA Benefit Elections (Please enter your FSA Elections below)

☐ Health Flexible Spending Account (FSA)	☐ Dependent Care Assistance Plan (DCAP)
Annual Election Amount: **(Not to exceed IRS or Plan maximum)**	Annual Election Amount: **(Not to exceed IRS or Plan maximum)**

- Elections must be made in advance of the start of the plan year and cannot exceed the IRS or Plan maximum contribution amount.
- Election amounts will be deducted pretax.
- Health FSA funds are available on the first day of the plan year for expenses incurred in the current plan year.
- Dependent Care funds are available as the funds are withheld from your payroll.
- All unused funds remaining at the end of the Plan's Runout or Grace Period (as applicable) will be forfeited back to your employer.

Authorization (Please acknowledge the below and sign)

- I understand that all elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.
- I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse and dependents. I also understand that daycare reimbursements will be available only for qualifying daycare expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.
- I understand that I must submit a claim and appropriate documentation (e.g., explanation of benefits, itemized bill) for out-of-pocket medical, and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Account Plan for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Participant Signature: _____ Date: _____