How to Complete your Flexible Spending Account (FSA) Enrollment Form

Attached is the 2024 Flexible Spending Account enrollment form for Medical, Dependent Care, and Commuter Reimbursement.

Please complete this form electronically.

Here are step by step instructions on how to complete the form:

1. At the top, select if you are RWU or SOL. Then in the first section complete the fillable fields with all of your personal information.

2. In the second section you will elect what benefit(s) you are enrolling in for 2024:
   - **For each benefit you elect**, enter the **yearly amount** you wish to contribute by putting the total contribution in the box labeled "**Annual Contribution**" and the form will calculate the Pay Period amount automatically.

*****If an amount is entered in the "Annual Contribution" field, you are enrolling in the benefit.*****

3. In the third section, if you have Dependents on your plan enter their information in the **Dependent(s) Information** section.

4. Lastly, **E-sign and Date** the form and **Submit to Human Resources, at the contact information below, no later than November 30th.**

PLEASE SUBMIT YOUR FORM

Email (preferred) to: **human_resources@rwu.edu**

Fax to: Human Resources at (401) 254-3370

****For Continuing Participants****

Your debit card is valid for 3 years, but you still need to enroll each year.

If your card expires on 12/31/23, you will be issued a new card for 2024.

Flexible Spending Medical, Dependent Care and/or Commuter and Transit Account Enrollment Form

Blue Cross Blue Shield of Rhode Island

Please Send Completed Form To:

Human Resources
One Old Ferry Road, Bristol, RI 02809
Email: human_resources@rwu.edu
Phone: 401-254-3028
Fax: 401-254-3370

Please Check Your Location: ☐ **Roger Williams University** ☐ **School of Law**

Employee Information:

Employer Name: Roger Williams University and School of Law		Effective Date: 01/01/2024	
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
Email Address:	Phone #:		
Date of Birth:	Social Security No. (Last 4 Digits):		

*****For Each Benefit in Which You Wish to Enroll, Please Enter the Yearly Amount in the "Annual Contribution" Field(s) Below*****

Medical Reimbursement Account:

The 2024 IRS Maximum Annual Contribution is **$3,200**

Annual Contribution: ☐ Per Pay Period: $ 0.00

# of Pay Periods: 26
First Payroll Date: 1/12/24

Dependent Care Reimbursement Account:

The 2024 IRS Maximum Annual Contribution is **$5,000**
A letter from your provider is required

Annual Contribution: ☐ Per Pay Period: $ 0.00

# of Pay Periods: 26
First Payroll Date: 1/12/24

Commuter Reimbursement Account:

The Maximum Annual Contribution is **$300** per month each for Parking & Transit
That is an annual amount of **$3,600**
For each benefit

PARKING Annual Contribution: ☐ Per Pay Period: $ 0.00

# of Pay Periods: 26
First Payroll Date: 1/12/24

TRANSIT Annual Contribution: ☐ Per Pay Period: $ 0.00

# of Pay Periods: 26
First Payroll Date: 1/12/24

Dependent(s) Information *(if applicable)*:

Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No

** Please list additional dependents on back side of this enrollment form*

I Understand That:

(1) My employer will be deducting the allocations stated above from pay check for the purposes of funding my Flexible Spending Account plan(s).

(2) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for each new plan year.

(3) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status, marriage, divorce, death of spouse or child, birth or adoption of child, termination or commencement of employment of a spouse, or such other qualifying events allowed by the Internal Revenue Code that will permit a change or revocation of an election.

(4) London Health Administrators may reduce, cancel, or otherwise modify this agreement in the event they believe it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

(5)This agreement is subject to the terms of the Company's Flexible Spending Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

(6) By signing this form, I agree to the terms and procedures listed herein.

Employee Signature: _____ **Date:** _____

Plan Administrator: London Health Administrators