THE TULALIP TRIBES OF WASHINGTON
HEALTH FSA ELECTION FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ Effective Date_____

Name_____ Waive Participation_____ (initial)
(Last) (First) (MI)

Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ___ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____

I prefer to be contacted regarding my FSA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

DEPENDENT INFORMATION (Must List ALL eligible Dependents Affected by Enrollment)

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS#	Date of Birth
Employee		*Self*			
Dependent					
Dependent					
Dependent					
Dependent					

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

HEALTH FLEXIBLE SPENDING ACCOUNT - Employer Contribution ☐ NO ☐ YES $_____Annual Benefit

PAYROLL SCHEDULE ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

EMPLOYEE ELECTION $_____/Per Pay Period $_____/Annually (from your Effective Date until October 31)

TYPE OF PLAN: ☐GENERAL PURPOSE ☐LIMITED PURPOSE / POST DEDUCTIBLE ☐EMPLOYEE ONLY

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs. Changes must be submitted within 30 days of the qualifying event.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits from my Insurance Provider, itemized bill, etc.) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed.

I understand that the plan provisions will require that all Health FSA participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options, if applicable (see your Summary Plan Description regarding COBRA qualifications). If the continuation for the Health FSA is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize The Tulalip Tribes of Washington to make pretax deductions from my salary on the payroll schedule I have elected above. I understand that to stop such deduction, I must notify The Tulalip Tribes of Washington Benefits office in writing with my request, and revoke this authorization.

Any unused dollars remaining in my Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that I participate in the plan in order to be eligible for reimbursement.

Employee's Signature _____ Date: _____

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