EMPLOYEE ENROLLMENT FORM
Flexible Spending Account (FSA)

Instructions: Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected. **Return the completed and signed form to your employer for processing**.
For Employer to complete where applicable:

Client/Company Name:	County of Dane dba Dane County	TASC ID #:	4023-1028-9439
Employer Class:		Employer Division:	
Participant Plan Effective Date:	01/01/2025	First Payroll Date:	01/10/2025

INDIVIDUAL/PARTICIPANT INFORMATION

Legal First Name:		MI:		Last Name:	
TASC ID # (if known):		Personal Email:			
Primary Phone #:		Mobile Phone #[1]:			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	
Date of Birth:		Hire Date:		Payroll Frequency:	Bi-Weekly

All fields are required for account setup. Information is confidential and is not used for marketing purposes.
[1]*Please provide this information if available (not required).*

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

I select the following benefits and amount(s) to be deducted pretax:	Employee Annual Salary Reduction Election Amount	EMPLOYER Annual Contribution	Maximum Employee Annual Election
☐ Healthcare FSA	$	$ 0.00	$ 3,300
☐ Dependent Care FSA (Daycare Expenses)	$	$ 0.00	$ 5,000

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.
To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** (No fee)	
2	**Dependent Name (First, MI, Last):** (Additional fee may apply)	
3	**Dependent Name (First, MI, Last):** (Additional fee may apply)	

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

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AUTHORIZATION

I certify the above information to be true to the best of my knowledge. I further certify that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support, and that the expenses I claim from my Healthcare FSA will not have been incurred by a spouse who is enrolled in a Health Savings Account. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my FSA(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my employer and/or payroll processor. I understand additional TASC Cards issued to my spouse or dependent(s) will provide the named individual(s) with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual(s) and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my employer. I acknowledge and agree that use of the TASC Card in violation of Dane County's enrollment agreement or the Cardholder Agreement may result in the invalidation and forfeiture of my TASC Card. If TASC determines that an expense charged on my card was not a qualified expense under the plan according to IRS rules, I shall immediately reimburse the plan for the entire amount of the unqualified expense. If I fail to reimburse the plan in a timely manner, I understand the amounts may be withheld post-tax from my wages or any other pay due in order to reimburse the unqualified expense.

Signature: _____ Date: _____

ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable benefit account type:

1. **Healthcare FSA Election:** The amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental, orthodontic, and eye care expenses. Participants may elect a maximum based on the current IRS limits. Your employer's plan maximum may be less than the IRS maximum. Review your Summary Plan Description (SPD) for your specific plan maximum. Your election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement of eligible expenses on the first day of the plan year.
2. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the Plan Year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single. Plan funds are available as they are contributed.

IMPORTANT NOTE:
How Cafeteria Plans affect Social Security Benefits: Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs available under an FSA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.

For enrollment assistance: call toll-free 800-422-4661
Have your enrollment form, employer name, and the Client ID# ready.
Find all IRS limits on our website: www.tasconline.com/resources/benefit-limits