wexinc.com
868-451-3399

Diocese of Winona-Rochester Group

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

January 1 – December 31, 2024 Calendar Year Plan

I waive the following:
☐ **Medical/Limited Flex**
☐ **Dependent Care Flex**

Step 1: Employee Information – Required Fields

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Daytime Phone: _____ Marital Status (Married/Single): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Date of Birth: _____ / _____ / _____

Step 2: Waiving Coverage (Note: Only complete this step if you are NOT electing to enroll in a Flexible Spending Account)

Participant Signature: **Date:**

Step 3: Enrollment and Election Information (Effective Date: Begins January 1 or 1st of the month following date of hire)

A. Medical Flexible Spending Account - If you have an HSA, you are not eligible to enroll in this account.

DOW-R minimum $150; DOW-R maximum $3,050

☐ I want to contribute a total of $ _____ during this plan year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

B. Limited FSA - If you have an HSA, you are eligible to enroll in this account.

Are you or your spouse participating in a Health Savings Account (HSA)? If yes, your limited FSA must be limited to dental and vision expense reimbursement until the IRS Statutory Deductible has been met. Contact "WEX" to remove the limit when your deductible is met.

DOW-R minimum $150; DOW-R maximum $3,050

☐ I want to contribute a total of $ _____ during this plan year to my Limited Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

C. Dependent Care Flexible Spending Account:

DOW-R minimum $150; IRS maximum: $5,000 ($2,500 if married but filing separate tax returns)

☐ I want to contribute a total of $ _____ during this plan year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Flexible Spending Account Enrollment Form Signature:

All enrollees in medical, limited FSA, and/or dependent care must sign/date

I authorize my employer to reduce my pay based on a per-pay-period for the annual amount indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

Participant Signature: _____ **Date:** _____

Questions? Contact Benefits (Julia Sandsness) at the Diocese of Winona-Rochester at (507) 858-1268 or email benefits@dowr.org or contact "WEX" at (866) 451-3399.

Location - Upload completed forms to your location's Dropbox.

Benefit Office	Location Payroll Reduction(s)	Location Name/#	
FLEX	Effective Date: _____	Medical Mo Amt: _____	Dependent Care Mo Amt: _____