Discovery Benefits®

City of Alameda- California
Flexible Spending Account (FSA)
2021 Enrollment Form

Please complete and submit this enrollment form to the Human Resources Department by email at hr@alamedaca.gov. Forms submitted to Discovery Benefits cannot be processed. This form cannot be processed without all fields marked with [*] completed.

*= Required Fields

Step 1: Participant Information

*Participant Name (First, MI, Last) | *Social Security Number - -

*Participant Mailing Address | Email Address (If provided, all notifications will be sent via email)

*City | *State | *Zip Code

Day Telephone - - | *Birth Date (mm/dd/yyyy) | *Hire Date (mm/dd/yyyy)

Gender (Select One): ☐ Female ☐ Male

Marital Status (Select One): ☐ Married ☐ Single

Step 2: Enrollment and Election Information

		Medical FSA $2,750 Annual Limit		**Dependent Care Account** $5,000 annual limit (2,500 if filing taxes separately)
***Annual Election**		$		$
***Number of Pay Periods** (if enrolling mid-year, please enter the number of remaining pay periods within the plan year)		÷		÷
***Per Pay Period Amount** (to be deducted each pay period)		=		=
***Date of First Payroll** (mm/dd/yyyy)				
***Participant Effective Date (mm/dd/yyyy)**				
Pay Frequency		(Bi-Weekly/26 pay period per calendar year)		

Step 3: Authorization for Administrative Fee

☐ By checking this box, you understand that you are responsible to pay the Administrative Fee of $4.25 per month for participating in the FSA program. The deduction will be taken monthly from your paycheck on an after-tax basis. Please note that this fee is in addition to your annual election.

Step 4: Authorization

I authorize my employer to reduce my pay on a per pay period basis as 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**

Return your completed enrollment form to the Human Resources Department at hr@alamedaca.gov.