Seattle Housing Authority – Flexible Spending Arrangement Enrollment Form Plan Year: 1/1/2021-12/31/*2021*

Last Day to Submit Claims: 3/31/2022

navia benefit solutions

Employee Information – Please write legibly to ensure proper enrollment

Last Name, First Name	**SSN #**

Home Address (Street, City, State, Zip Code)			
Date of Birth	**Phone Number**	**Personal Email Address**	**Effective Date**

Benefit Elections

Section 125 Benefit	Yes/No	Paycheck Deduction	# of Paychecks	Annual Election
Health Care FSA Maximum of $2,750.00 per plan year	❑ Yes ❑ No	$_____		$_____
Day Care FSA Maximum of $5,000.00 per plan year (or $2,500 if you're married and filing taxes separately)	❑ Yes ❑ No	$_____		$_____
Premium Conversion The group insurance premiums you pay through your paycheck are automatically deducted pre-tax. Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.				Automatic

Debit Card & Direct Deposit

Navia Debit Card – You may use the card to pay for expenses directly from the funds in your Health Care FSA. There is no cost for the initial card. The cards are valid for 3 year periods; if you've previously received the card then it will be reloaded with your new election. You must provide a valid email address to use the card.	Automatic
Direct Deposit – Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.	Enter banking information for Direct Deposit through online account at Navia.com.

Signature

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

❑ **YES**, the above benefits have been explained to me and I elect to participate as indicated

❑ **NO**, the above benefits have been explained to me and I decline participation

Employee Signature	**Date**
X	

<u>Completed Enrollment Forms must be returned to Human Resources</u>