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**Flexible Spending Account (FSA) Enrollment Form**

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| Account Holder Profile Information | | | |
| First Name\*: | Last Name\*: | | SSN\*: |
| Date of Birth\*: | Email Address\*: | | |
| Mailing Address Line 1\*: | | | |
| Mailing Address Line 2: | | | |
| City: | State: | | Zip: |
| Home Phone: | | Cell Phone: | |
| Gender: □Male □Female | Date of Hire: | | Employer: |

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| --- | --- | --- |
| Election | | |
| I authorize my employer to make the following pre-tax deductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event such as marriage, divorce, death, or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn’t eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck. | | |
| Effective Date: | | 1st Payroll Deduction Date: |
|  | | |
| Flexible Spending Account | **Employee Annual Election: $** | |
| Dependent Care FSA *(if applicable)* | **Employee Annual Election: $** | |

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| --- | --- |
| Authorization | |
| Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_ | Employer Authorization  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Debit Card and Direct Deposit Information**

* A Debit Card will automatically be issued in the account holders name and shipped to the address above. Once the enrollment is processed it should arrive within 10-14 days.
* If you already have a Consumer Health Solutions or Cross Insurance Debit Card, you will **not** receive a new card.
* You will receive an enrollment email sent to the email listed above with login instructions for our online portal.
* Please log into the portal and add your direct deposit information for any reimbursements from your FSA. You will be asked to complete a **Bank Verification** process. Instructions are displayed in the portal.

Consumer Health Solutions: Monday—Friday 8:30 AM-4:30 PM EST

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| --- | --- | --- |
| Speaker phone  Voicemail:  (877) 230-8650 | Email  HealthAccounts@CronsumerHealthSolutions.com | Fax  Fax: (978) 451-0981 |

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Description automatically generated

Download the “**Consumer Health Mobile”** App on iPhone or Android to view your balance, use the Eligible Expense Scanner, add direct deposit, and submit claims for reimbursement.