CS-1773
Rev 12/2023

☐ **General Purpose Health Care FSA**

☐ **Limited Purpose Health Care FSA**

State of Michigan
Civil Service Commission
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
800-505-5011
Email: MCSC-EBD@mi.gov
Fax: 517-284-0078

Midyear Enrollment

☐ **Return to Work**

☐ **Qualifying Life Event Change**

(please supply supporting documentation)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT
MIDYEAR ENROLLMENT FORM

Note: New hires should contact the MI HR Service Center at 877-766-6447 for enrollment in Flexible Spending Accounts.

Instructions: Complete this form to enroll in a Health Care Flexible Spending Account for the current calendar year. Sign and date the form, retain a copy for your records, and submit to Employee Benefits Division via one of the methods listed above. **Midyear enrollment must occur within 31 days of the qualifying life event; (e.g., birth of child, change in marital status, etc.), and be submitted with supporting documentation.**

EMPLOYEE INFORMATION

Name			**Effective Date (Civil Service Use Only)**
Home Address			**Work Phone** **Ext.**
City	**State**	**Zip Code**	**Home Phone**
Employee ID Number		**State E-mail Address**	

AUTHORIZED PAYROLL DEDUCTIONS

Enter the total annual amount (referred to as Annual Goal) you're requesting for your health care expenses for services provided beginning with the effective date of this enrollment through December 31st of the current calendar year.

Annual Amount (Annual Goal)

$

The amount you enter cannot exceed the Annual Goal amount as defined in the FSA Plan Booklet located at www.mi.gov/FSA and will be divided evenly and deducted via pre-tax payroll deductions over the remaining biweekly pay periods in the current calendar year.

I authorize the State of Michigan to reduce my gross salary in the amount specified above. I understand I am making a binding election for the entire calendar year and authorize the State of Michigan to adjust my pay accordingly.

I certify that I have read the rules governing contributions and reimbursements as described in the FSA Plan Booklet and I understand:

1) *I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents.*
2) *I will not seek reimbursement through any other source.*
3) *I will collect and maintain sufficient documentation to validate the foregoing.*
4) *That any amounts remaining in my FSA after the claim submission deadline or above the carryover amount must be forfeited.*
5) *That it is my responsibility to make sure that the annual amount specified on this enrollment form is accurate.*
6) *That my biweekly deduction may not be stopped or changed during the year except in the case of an IRS-approved change in status.*
7) *The information provided on this form is true and complete.*

I agree and understand that any misstatement or falsification of material facts will result in my removal from the FSA, may cause an IRS and/or state audit with possible additional tax, interest, and penalties; which may result in civil and/or criminal prosecution; and may jeopardize my employment status with the State of Michigan.

Employee's Signature	**Date**