

- General Purpose Health Care
 Limited Purpose Health Care

State of Michigan
Civil Service Commission
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
800-505-5011

Mid-Year Enrollment

- Return to Work
 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 the Health Care Flexible Spending Account for the current calendar year. Sign and date the form, retain a copy for your records, and mail to the above address or fax to 517-284-0078. **Midyear enrollment must occur within 31 days of the qualifying life event; (e.g., birth of child, change in marital status), and be submitted with supporting documentation.**

EMPLOYEE INFORMATION				
Name			Effective Date (Civil Service Use Only)	
Home Address			Work Phone <div style="text-align: right;">Ext.</div>	
City	State	Zip Code	Home Phone	
Employee ID Number		State E-mail Address		
AUTHORIZED DEDUCTIONS				
Calculate only the amount needed to cover your medical care expenses for services provided beginning with the effective date of this enrollment through December 31.				
Biweekly Amount \$	Times X	Pay Periods (1 to 26)	Equals =	Annual Amount \$
The biweekly deduction amount times the number of pay periods cannot exceed an annual amount as defined in the State of Michigan Plan Booklet located at www.michigan.gov/FSA.				
I authorize the State of Michigan to reduce my gross biweekly salary in the amount specified. I understand I am making a binding election for the entire plan 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 Flexible Spending Account Booklet and I understand:				
<ol style="list-style-type: none"> 1) <i>I will only use my Spending Account to pay for IRS-qualified expenses and only for my IRS-eligible dependents.</i> 2) <i>I will not seek reimbursement through any other source.</i> 3) <i>I will collect and maintain sufficient documentation to validate the foregoing.</i> 4) <i>That any amounts remaining in my Spending Account after timely claims have been submitted must be forfeited.</i> 5) <i>That it is my responsibility to make sure that the deduction specified on this enrollment form is accurate.</i> 6) <i>That my biweekly deduction may not be stopped or changed during the year except in the case of an IRS-approved change in status.</i> 7) <i>The information provided on this form is true and complete.</i> 				
I agree and understand that any misstatement or falsification of material facts will result in my removal from the Spending Account, 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