Concordia Plan Services
The Lutheran Church—Missouri Synod
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CONCORDIA PLANS

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Flexible Spending Account Enrollment Form

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Employer/Employee Information

Employer Name:_____ CPS ER#: _____ Plan Year _____

City:_____ State: _____ Zip Code:_____

Employee Name:_____
(Last) (First) (MI)

Street Address:_____

_____
(City) (State) (Zip Code)

Daytime Phone Number:_____ Date of Birth:_____ Member ID: _____

B Employee Elections

Medical Flexible Spending Account 2025 Plan Year Maximum of $3,300.00

☐ I want to contribute a total of $_____ during this Plan Year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

Are you or your spouse actively contributing to a Health Savings Account?

☐ No

☐ Yes: Your medical FSA must be limited to the reimbursement of dental and vision expenses until your health plan deductible has been met.

Dependent Care Flexible Spending Account

Plan Year Maximum of $5,000.00 ($2,500.00 if married but filing separate tax returns).

☐ I want to contribute a total of $_____ during this Plan Year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the year.

C Employer Contributions

☐ My employer will contribute a total of $_____ during this Plan Year to my Medical Flexible Spending Account.

☐ My employer will contribute a total of $_____ during this Plan Year to my Dependent Care Flexible Spending Account.

Note: The employer can contribute up to $500 to all eligible workers without the employee contributing. When employer is contributing an amount over $500, the employer's contribution cannot exceed the employee's election. Employer contributions are not considered part of the maximum employees can contribute.

D Signature

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited unless my employer allows dollars to roll in to the next Plan Year.

_____ _____
Account Holder Signature **Date**

Please return this form along with other supplementary enrollment forms, if applicable, to your congregational treasurer, business manager, or HR office by the deadline requested by your employer.