2024 Flexible Spending Account & Dependent Care Enrollment Form

Employee #_____

Name_____

Address_____

City, State, Zip_____

Note: Employees enrolled in an HSA/High Deductible Plan (HDP or LPHDP) may only use a Medical Reimbursement Account for Dental and Vision expenses.

Flexible Spending Accounts:

☐ Medical Reimbursement Account: January 1st to December 31st
Annual Contributions: Minimum $100, Maximum $3,050

$_____ per pay period x ____ remaining pay periods = $_____ Plan Year Total

☐ Dependent Care Account: January 1st to December 31st
Annual Contributions: Minimum $100, Maximum $5,000 ($2,500 if married filing separate Federal Income Tax returns)

$_____ per pay period x ____ remaining pay periods = $_____ Plan Year Total

Authorization

I have reviewed the terms of Consolidated Communications' Flexible Spending Accounts Plan. I understand that the amount that I elect will be deducted from my paycheck on a pre-tax basis and the deductions cannot be changed until the next plan year unless there is a qualifying event. I have read and agree to the terms of participation.

_____ _____
Employee Signature Date

Return Form to HR Services:
HRServices@consolidated.com
936.756.2822 (fax)

For Employer Use Only

Union Code / Pay Group	Entered in PS	Initial