THE HOPI TRIBE

Enrollment Form: Flexible Spending Account 2026

Employee Information			
Last Name	**First Name**	**MI**	**SS#**
Address	**City**	**State**	**Zip Code**
Date of Birth	**Date of Hire**	**Effective Date of Coverage**	
Telephone Number	**Email Address**		

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand this election is for the **2026 Plan Year**, however, if I were to leave employment prior to the end of this Plan Year, my Plan Year would end as of my termination date. I understand I can only be reimbursed for services rendered during this Plan Year and services prior to my termination of employment. I understand this agreement cannot be amended before the next annual election absent of a qualifying change in my family circumstances or the termination of this Plan.

Upon election, I understand that the FSA Benefits Card is to be used only for eligible Medical care expenses (and those of my spouse and/or dependent children). I understand that with each use of the card, I am reaffirming a certification (printed on the back of the card) that any expense paid with the card has not been reimbursed and I will not seek reimbursement under any other plan covering health benefits. I also agree to acquire and keep sufficient documentation (e.g., invoices and receipts) for expenses paid with the card. I understand that I will be notified in writing, in the event my card is used to pay for a questionable expense and I will be required to provide supporting documentation. Furthermore, I understand that it is my responsibility to repay my Flexible Spending Account for any ineligible expenses that were paid. I also understand that if the repayment request is unsuccessful, then an amount equal to the improper payment will be withheld from my paycheck. To ensure that no further violations occur, I understand that I may be denied access to the card until the amount is repaid.

I agree, until such time as I notify my employer in writing of an eligible change in family status, or such time when my employer no longer offers this program, to the terms and conditions of the flexible spending account as defined in the plan document. My employer and I agree that my pay will be reduced annually by the amount I specified for the benefit option(s) I select under the plan on a pretax basis. In addition, I understand that I can roll over up to **$680** at the end of the eligibility period for the plan year. Any amount over that not used for eligible expense reimbursement, will be forfeited.

The amount of my election for the 2026 Plan Year (Not to exceed the IRS Limit of **$3,400**) for each option selected is set forth below.

☐ I hereby elect to participate in the Flexible Spending Account and my first payroll deduction will begin: _____

	Per Pay Period		**# Pay Periods**		**Annual Election**
Health Care Reimbursement Election	$ _____	X	_____	=	$ _____

_____ _____

Employee Signature Date

SUMMIT

Summit is the administrator of your Plan.
Please return this form to your Employer.