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Flexible Spending Accounts

Enrollment Form

Participant Information

Employer Name: ____________________ **Employer/ Location:** ____________________

Employee Name: ____________________ (First Name) ________ (Middle Initial) ____________________ (Last Name)

SSN/EEID: ____________________ **Date of Birth:** ____________________

Current Address: ____________________ (Street Address)

____________________ (Floor or Apt No.)

____________________ (City, State Zip)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separate

Phone Number: ____________________ (Cell Phone Number) ____________________ (Home Phone Number)

Health Care Spending Account:

The Health Care Spending Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

☐ **Yes, I want to participate**
☐ **No, I do not want to participate**

$ ____________ ÷ ____________ = $ ____________

Plan Year Contribution	**# Pay Periods in the Plan Year**	**Pay Period Pre-Tax Contribution**

Dependent Care Spending Account:

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you or your spouse (if applicable) to work or attend school on a full-time basis.

☐ **Yes, I want to participate**
☐ **No, I do not want to participate**

$ ____________ ÷ ____________ = $ ____________

Plan Year Contribution	**# Pay Periods in the Plan Year**	**Pay Period Pre-Tax Contribution**
Max of $5,000 ($2,500 if filing taxes separate)		

I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware that I have a grace period in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a status change and that I may experience future reductions in life, disability and Social Security benefits by participating in this Flexible Spending Plan.

PLEASE SUBMIT THIS COMPLETED FORM TO BENEFITS COORDINATOR. LATE ENROLLMENTS WILL NOT BE ACCEPTED.

Participant Signature ______________________________ **Date** ____________

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