Flexible Spending Account Enrollment Form

Employee Information

Employee's Name (Last, First, Middle)	Social Security Number		Date of Birth
Employee's Address	City	State	ZIP
Phone Number	Department/Employee Number		

Dependent Information

Spouse's Name	Social Security Number	Date of Birth
Dependent Name	Social Security Number	Date of Birth
Dependent Name	Social Security Number	Date of Birth
Dependent Name	Social Security Number	Date of Birth
Dependent Name	Social Security Number	Date of Birth
Dependent Name	Social Security Number	Date of Birth

Health Care (CLect)

$130 minimum ($5) - $2750 Annual Maximum ($105.76)

[ ] I elect to participate. Please deduct $_____ per pay period for an annual total of $_____

Dependent Care

$5000 Annual Maximum, $2500 if married filing separate

[ ] I elect to participate. Please deduct $_____ per pay period for an annual total of $_____

Authorization for Flexible Spending Account

Authorization: I understand that by signing and submitting this form, I authorize the adjustment of my annual taxable salary based on my elections above, with the "tax protected" funds being transferred into my Flexible Spending Account. My election cannot be changed during the plan year, unless I experience an eligible qualifying event. I further understand that this form must be signed and dated prior to my plan effective date to be eligible to participate in this plan year. Any unused amounts remaining in my Health Care FSA account at the end of the plan year over the amount of $500.00 will be forfeited. Any unused amounts remaining in my Dependent Care FSA at the end of the plan year will be forfeited. However, I will have a specified period of time (90 days) after the end of the plan year or date of my termination to submit receipts for reimbursement for services received during the plan year or employment period.

Signature_____ Date_____

HR Use Only
Effective Date:_____
Hire Date:_____
1st Payroll Deduction:_____