Flexible Spending / Cafeteria Plan Enrollment Form

Employer name:				Plan Year:
Last Name:	First Name:		M.I.	□ Male □ Female
				Social Security Number (Must be provided)
Street Address:		City:		State: Zip Code:
Home Phone Number: ( )	Date of Birth:	Date of Hire:	Division of Company:	□ Single □ Family
E-mail Address:				
Payroll Cycle: □ Weekly □ Bi-Weekly □ Semi-Monthly □ Monthly □ Other				
Date of first payroll withheld: Month _____ Day _____ Year_____				

Account Type (**Note:** Not all accounts may apply to your company)	**Election Amount**
Health FSA (example: Doctor co-payments, eye glasses)	_____ Annual $2,750.00 annual max contribution
Dependent Care Assistance FSA	_____ Annual $5,000.00 annual max contribution

Minimum reimbursement amount for manual check is $25

PLEASE NOTE: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION

I hereby elect the benefits indicated above. I have read and understand the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT_____**DATE** _____

Please return all enrollment forms to your Employer

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