

# Flexible Spending Account Enrollment Form

## Step 1: Participant Information

\*=Required Fields

<input style="width:100%; height:20px;" type="text"/> *Employer Name (Do not abbreviate)	<input style="width:100%; height:20px;" type="text"/> *Department
<input style="width:100%; height:20px;" type="text"/> *Participant Name (First, MI, Last)	<input style="width:100%; height:20px;" type="text"/> *Social Security Number
<input style="width:100%; height:20px;" type="text"/> *Participant Mailing Address	<input style="width:100%; height:20px;" type="text"/> Email Address (If provided, all notifications will be sent via email)
<input style="width:100%; height:20px;" type="text"/> *City	<input style="width:100%; height:20px;" type="text"/> *State      *Zip
<input style="width:100%; height:20px;" type="text"/> Day Telephone	<input style="width:100%; height:20px;" type="text"/> *Birth Date (mm/dd/yyyy)
<input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input style="width:100%; height:20px;" type="text"/> *Hire Date (mm/dd/yyyy)
*Payroll Cycle	<input style="width:100%; height:20px;" type="text"/> Date of first payroll withholding

## Step 2: Spouse and Dependent Information

	*Name (Last, First)	*Date of Birth	*Social Security Number
Spouse:			
Dependent:			
Dependent:			
Dependent:			

## Step 3: Election

Account Type	Election Amount
Medical Expense Account	_____ Annually
Dependent Care Reimbursement	_____ Annually

Minimum Reimbursement amount for manual check is \$25

## Step 4: Authorization or Refusal

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 understand that if I am enrolled in a Health Savings Account (HSA) that I cannot enroll in the Medical FSA, and that I can only enroll in the Limited Purpose FSA if my employer offers this account.

SIGNATURE OF PARTICIPANT \_\_\_\_\_ DATE \_\_\_\_\_

## Step 5: Employer Authorization

Benefit Effective Date	Date of first payroll withholding

SIGNATURE OF EMPLOYER \_\_\_\_\_ DATE \_\_\_\_\_