

FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

To enroll, complete the following information, sign the form, and return it to your Human Resources Representative.

EMPLOYEE INFORMATION (Please Print)

Employer Name: _____ Date of Hire: _____
 Employee Name: _____ Social Security: _____
 Address: _____ City, State, Zip: _____
 Date of Birth: _____ Gender: _____ Marital Status: _____
 Phone Number: _____ Email: _____

Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi Monthly ☐ Monthly

FLEXIBLE SPENDING ACCOUNT

I, the undersigned employee, apply to participate in the Healthcare and/or Dependent Care FSA Reimbursement Plan and agree with the Plan Document that with respect to, and in consideration of services to be rendered by the employee hereafter, the employee's salary will be reduced by the amount designated by the employee, such amount to be deposited to the employee's Medical or Dependent Care Reimbursement Account in this Plan in equal deposits and expended according to the rules applying thereto, for the purposes and in accordance with allocations below.

- ☐ I hereby elect **NOT** to participate in the Flexible Spending Accounts.
☐ I hereby elect to participate in the following Flexible Spending Accounts:

☐ **HEALTHCARE FSA (out-of-pocket medical, dental, vision, over-the-counter expenses)**

Maximum Election: \$3,400.00

_____ x _____ = _____
 Amount Per Pay Period Number Of Periods Annual Election

☐ **DEPENDENT CARE FSA (out-of-pocket day care expenses)**

Maximum Election: \$7,500.00

_____ x _____ = _____
 Amount Per Pay Period Number Of Periods Annual Election

I have been advised of the provisions of the Plan and understand the legal plan documents are controlling. I further recognize that I must allocate my Salary Reduction Account dollars in advance and that any dollars not used by the end of the Plan Year may be forfeited. Federal law does not permit an employee to revoke a benefit election once made for the current plan year, except as detailed in the Flexible Benefit Plan Document, and in the Summary Plan Description of the Plan, both available from the employer.

Employee Signature

Date

TO BE COMPLETED BY THE EMPLOYER

Department/Location: _____

FSA Effective Date: _____ FSA Payroll Contribution Start Date: _____

Employer Signature

Signature Date