



PO Box 5308  
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## FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

EMPLOYER:	PLAN YEAR:		
EFFECTIVE DATE:	SSN:		
NAME:	BIRTH DATE:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single
MAILING ADDRESS:	PHONE:		
CITY:	ST:	ZIP:	

**PAYROLL DEDUCTED PREMIUM BENEFITS elected under IRC Section 125**

Payroll deducted premiums will be on a pre-tax basis for the current and all subsequent plan years based upon this election form until a signed election revocation is provided by the participant.

### FLEXIBLE BENEFITS ELECTION AUTHORIZATION

#### MEDICAL SPENDING ACCOUNT

#### DEPENDENT CARE ACCOUNT

ELECTION PERIOD:       Monthly    Semi-Monthly    Semi-Weekly    Weekly

\$ \_\_\_\_\_ PER PAY PERIOD ELECTION

\$ \_\_\_\_\_ PER PAY PERIOD ELECTION

\$ \_\_\_\_\_ ANNUAL AMOUNT ELECTED  
(Pay period amount x number of pay periods)

\$ \_\_\_\_\_ ANNUAL AMOUNT ELECTED  
(Pay period amount x number of pay periods)

Yes, please issue me a Prepaid Benefits Card

GROUP HEALTH INSURANCE MONTHLY PREMIUM AMOUNT: \$ \_\_\_\_\_

**CERTIFICATION:** *I certify that these are my benefit elections and that:*

1. I authorize the "before-tax" deduction of a portion of my pay based on the elections above.
2. My medical spending account election is for medical, dental, and vision expenses for myself, my spouse (if filing jointly), and my tax dependents.
3. My dependent care account election is for the care of my tax dependent children, under age 13, or individuals unable to care for themselves, residing with me at least 8 hours each day.
4. I am aware that my unused contributions made under this plan cannot be refunded to me and become the property of my employer.
5. Reimbursement account claims must be accompanied by documentation for the out-of-pocket expense.
6. I understand that coverage applies only to expenses incurred during participation.
7. I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Declination of Participation:** My employer's healthcare spending account and dependent account have been explained to me, I have been given the opportunity to participate and have elected not to do so.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_