Health/Dependent Care Flexible Spending Account Enrollment Form

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

First Name _____ M.I. _____ Last Name _____

Date of Birth ☐☐ – ☐☐ – ☐☐☐☐
MM DD YYYY

Address _____

City _____ State _____

Zip Code _____ – _____ Day Phone _____ – _____ – _____

Email _____

☐ **I ELECT TO HAVE MY MEDICAL PREMIUMS WITHHELD PRE-TAX.**

I have reviewed the terms of my employer's Plan and I understand that I may elect coverage under either or both of the accounts below, subject to the terms of the Plan, for the Plan Year _____.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

CONTRIBUTION PER PAY PERIOD $ ☐☐☐,☐☐☐.☐☐ | NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR X ☐☐ | = YOUR ANNUAL ELECTION AMOUNT ☐☐☐,☐☐☐.☐☐

CANNOT EXCEED $5,000 PER HOUSEHOLD

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

CONTRIBUTION PER PAY PERIOD $ ☐☐,☐☐☐.☐☐ | NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR X ☐☐ | = YOUR ANNUAL ELECTION AMOUNT ☐☐,☐☐☐.☐☐

Please select your enrollment option below, then sign and date your form and submit to your benefit services department:

☐ I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year noted above will be forfeited.

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

☐ I decline enrollment in my employer's Flexible Spending Account Plan.

Employee Signature _____ Date _____

Employer Section: ADP FSA Client ID _____ Employee ADP Company Code _____ Effective Date of Employee Election _____