

FLEXIBLE SPENDING/CAFETERIA PLAN ENROLLMENT FORM



EMPLOYER NAME:	PLAN YEAR: 20_____	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER <small>(MUST BE PROVIDED)</small>
EMPLOYEE LAST NAME:	FIRST NAME	M.I.		
STREET ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE NUMBER	DATE OF BIRTH	DATE OF HIRE	DIVISION OF COMPANY	<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY
E-MAIL ADDRESS				
PAYROLL CYCLE <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER				
DATE OF FIRST PAYROLL WITHHOLD:		MONTH	DAY	YEAR

ACCOUNT TYPE <small>NOTE: NOT ALL ACCOUNTS MAY APPLY TO YOUR COMPANY</small>	ELECTION AMOUNT <small>NOTE: NOT ALL ACCOUNTS MAY APPLY TO YOUR COMPANY</small>	SHORT PLAN YEARS / MID-YEAR ENROLLEES <small>(PLEASE NOTE BELOW)</small>
MEDICAL EXPENSE REIMBURSEMENT <small>EXAMPLES: DOCTOR CO-PAYMENTS, EYE GLASSES</small>	_____ ANNUAL	YOUR ELECTION AMOUNT WILL BE THE FULL AMOUNT YOU ARE ELECTING EVEN IF YOU WILL NOT BE ENROLLED IN THE PLAN[S] FOR A FULL 12 MONTHS. THIS AMOUNT WILL NOT BE PRORATED FOR YOUR SHORT PLAN YEAR.
DEPENDENT CARE ASSISTANCE <small>EXAMPLES: DAYCARE CENTERS, AFTER SCHOOL PROGRAMS, ELDERCARE <i>Refer to page 16 for dependent care daycare assistance account guidelines.</i></small>	_____ ANNUAL	
INDIVIDUAL PREMIUM REIMBURSEMENT	_____ ANNUAL	
ADOPTION ASSISTANCE	_____ ANNUAL	

MINIMUM REIMBURSEMENT AMOUNT FOR PAPER 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 (FSA 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