Flexible Spending/Cafeteria Plan Enrollment Form

Employer Name: **Plan Year:**

Last Name	First Name	M.I.	☐ Male ☐ Female Soc. Sec. No. **(Must be provided)**
Street Address	City	State	Zip Code
Home Phone Number ( )	Date of Birth	Date of Hire	Division of Company: ☐ Single ☐ Family
Email Address:			
Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____ Date of first payroll withhold; Month _____ Day _____ Year_____			

Account Type (Note: Not all accounts may apply to your company)	**Election Amount**
Medical Expense Reimbursement (example: Doctor co-payments, eye glasses)	_____ Annual ($3,300.00 max)
Dependent Care Assistance	_____ Annual ($5,000 if married; $2,500 if single or married filing separately)
Adoption Assistance	_____ Annual ($17,280.00 max)

Minimum reimbursement amount for manual 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 (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 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