



Enrollment Form

Employer Name: _____	Employer/Location: _____	
Employee Name: _____	_____	_____
(First Name)	(Middle Initial)	(Last Name)
SSN/EEID: _____	Date of Birth: _____	
Current Address: _____	Gender: ☐ Male	
(Street Address)	☐ Female	
_____	Marital Status: ☐ Single	
(Floor or Apt No.)	☐ Married	
_____	☐ Married Filing Separately	
(City, State Zip)		
Phone Number: _____	_____	
(Phone Number)	(EMAIL ADDRESS)	

Health Care Spending Account:

The Health Care Spending Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

☐ Yes, I want to participate	\$ _____	÷	_____	=	\$ _____
☐ No, I do not want to participate	Plan Year Contribution \$3,400 annual maximum		# Pay Periods in the Plan Year		Pay Period Pre-Tax Contribution

Dependent Care Spending Account:

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you or your spouse (if applicable) to work or attend school on a full-time basis.

☐ Yes, I want to participate	\$ _____	÷	_____	=	\$ _____
☐ No, I do not want to participate	Plan Year Contribution \$7,500 annual maximum (\$3,750 if filing taxes separate)		# Pay Periods in the Plan Year		Pay Period Pre-Tax Contribution

You are eligible to participate in the flexible spending account plans the first of the month following 90 days of employment.

I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware that I have a grace period in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a status change and that I may experience future reductions in life, disability and Social Security benefits by participating in this Flexible Spending Plan

PLEASE SUBMIT THIS COMPLETED FORM TO BENEFITS COORDINATOR. LATE ENROLLMENTS WILL NOT BE ACCEPTED.

Participant Signature _____ **Date** _____