Flexible Spending Account (FSA)
ENROLLMENT FORM

PLEASE NOTE: This enrollment form is for Employer files only. Do not submit to Ameriflex.

Company Name _____

Employee Name _____

Member ID (your SSN) _____

Employee Email Address _____

Home Address _____

City _____ State _____ Zip _____

Telephone _____ Plan Year _____ through _____

Date of Birth _____ Effective Date _____

The company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement) I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay non-reimbursable medical, dependent care, and/or commuter expenses (if any) with after tax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

Medical Flexible Spending Account
$3,500 Max.
Annual contribution: $_____

Dependent Care Spending Account
$7,500 Max.
Annual contribution: $_____

I UNDERSTAND THAT:

(1) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

(2) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election). Note: This does not apply to Commuter Reimbursement Accounts.

(3) The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

By signing this form I agree to the terms and procedures listed herein.

_____ _____

Employee Signature **Date**