

**FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM
DEDUCTION AUTHORIZATION FORM**



Employer Name: _____

Check one of the following:

New Enrollment

Family Status Change

Effective Date: _____

Waiver of Election

Cancel Effective Date: _____

SECTION I: EMPLOYEE INFORMATION (Please print clearly.)

Full Name _____ Social Security Number _____
Last First Middle Initial
 Street Address _____ Office Phone (_____) _____
 City _____ State _____ Zip _____ Home Phone (_____) _____
 Date of Birth _____ Date of Hire _____

SECTION II: ELECTION INFORMATION

HEALTH CARE ACCOUNT

I would like to enroll in the Health Care Spending Account I do not wish to enroll in the Health Care Spending Account.

I wish to deposit the following amount on a pre-tax basis to the Health Care Spending Account.

Amount Per Pay Period	No. of Pay Periods through Plan Year End	Annual Account Total	New Annual Election
\$ _____	X _____	= \$ _____	\$ _____

DEPENDENT CARE ACCOUNT

I would like to enroll in the Dependent Care Account I do not wish to enroll in the Dependent Care Account.

I wish to deposit the following amount on a pre-tax basis to the Dependent Care Spending Account.

Amount Per Pay Period	No. of Pay Periods through Plan Year End	Annual Account Total	New Annual Election
\$ _____	X _____	= \$ _____	\$ _____

SECTION III: WAIVER OF ELECTION

My Signature certifies that I do not wish to enroll in either the Health Care Spending Account or the Dependent Care Spending Account.

Employee Signature _____ Date _____

SECTION IV: FAMILY STATUS CHANGE

Complete this section by describing the family status change including the names of individuals involved and the date the change occurred. Please use the space provided below:

SECTION V: PAYROLL DEDUCTION AUTHORIZATION

I understand that my annual contribution is within the legal limit of my tax filing status, and that my contributions can only be used to reimburse eligible expenses under each account. I also understand that I will forfeit any funds remaining in my account at the end of the plan period. I understand that by signing this form I am making a binding election for my contribution and that I cannot change my contributions unless I have a qualified family status change. My Social Security Benefits may be reduced since Social Security taxes are not paid on my contributions. My signature certifies that I authorize payroll reductions as contributions to my health and/or dependent care accounts as indicated above.

Employee Signature _____ Date _____