Flexible Spending Account Enrollment Form
Deduction Authorization Form

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EMPLOYER ____

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)

Employee's Name (Please Print Full Name) Last First Middle Initial		Employee's Social Security Number ☐☐☐■☐☐■☐☐☐☐
Address		Office Phone:
City State Zip		Home Phone:
Employee's Date of Birth / / Month Day Year	Date of Hire / / Month Day Year	

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 Department 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____________________