BeniComp Inc.
8310 Clinton Park Dr.,
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(260) 482-7400 ■ 1-800-837-7400

Flexible Spending Account Enrollment/Change Form

Deduction Authorization Form and Status Change

EMPLOYER _____

Check one of the following: ☐ New Enrollment ☐ Family Status Change ☐ Effective Date: _____ Date of First Pay Contribution:_____

☐ Waiver of Election ☐ Termination: Date of Term:_____ Date of Last Pay Contribution:_____

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 For details on reimbursement options, go to www.benicomp.com/fsa

☐ I would like to enroll in the Health Care Spending Account and deposit the following amount on a pre-tax basis:

Amount Per Pay Period		No. of Pay Periods Through Plan Year End		Annual Account Total
$_____	X	_____	=	$_____

Please check one of the following options for reimbursement: ☐ Automatic Reimbursement ☐ Manual Submission

Dependent Care Account

☐ I would like to enroll in the Dependent Care Account and deposit the following amount on a pre-tax basis:

Amount Per Pay Period		No. of Pay Periods Through Plan Year End		Annual Account Total
$_____	X	_____	=	$_____

Section III: Waiver Of Election

☐ I do not wish to enroll in the Health Care Spending Account. ☐ I do not wish to enroll in the Dependent Care Spending Account.

Employee Signature_____ Date_____

Section IV: Family Status Change New Amount Per Pay Period:_____ ☐ Medical New Amount Per Pay Period:_____ ☐ Dependent Care

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 and attach any necessary documentation.

_____

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_____

Effective Date of Form: July 2, 2009