

Flexible Spending Account Enrollment Form

Follow these easy steps:

1. Complete all entries on this Enrollment form. Please print.
2. Sign and date this form.
3. Submit it to your Human Resources Department.

Personal Information	
Employee Name (last name, first name)	Social Security Number
Mailing Address	City, State, Zip Code
Day Time Phone Number	Email Address
Date of Birth	Enrollment Status <input type="checkbox"/> New participant <input type="checkbox"/> Re-enrollment

Healthcare Account	Dependent Care Account
I. Annual Election (Maximum \$_____)	I. Annual Election (Maximum \$5,000)
II. Number of regular pay periods	II. Number of regular pay periods
III. Salary reduction per pay periods (I divided by II)	III. Salary reduction per pay periods (I divided by II)

Direct Deposit	
Withdrawals that you request from your Flexible Spending Account will be deposited directly into your checking account unless you notify us otherwise.	
Bank Name	Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings
City, State, Zip Code	Account Number
	Bank Routing Number

Authorization and Certification	
<p>I understand that:</p> <ul style="list-style-type: none"> • I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year. • I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events. • I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year. • Any funds left in my Healthcare and/ or Dependent Care Accounts at the close of the plan year will be forfeited. 	
_____ Employee Signature	_____ Date