



# Flexible Spending Account Health Care and Dependent Care Enrollment

## Employee Information

Social Security Number - -	Name (Last, First, Middle Initial)	Home Telephone Number ( )	Business Telephone Number ( )
Address (Street, City, State & Zip Code)			
Employer			

## Annual Contribution

Complete the following section to elect the type(s) of flexible spending account plan(s) you wish to participate in and designate the annual contribution amounts.

I wish to participate in the following flexible spending account plans:

	<u>Annual Contribution</u>
<input type="checkbox"/> Health Care FSA	\$ _____
<input type="checkbox"/> Dependent Care FSA ((\$5,000 maximum if single or married and filing joint federal income tax return; \$2,500 if married and filing separate federal income tax returns.)	\$ _____
<b>Total Annual Contribution</b>	<b>\$ _____</b>

## Authorization - Please read the following statements and then sign and date this form.

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred the same year **will be forfeited** in accordance with IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status.

Signature \_\_\_\_\_ Date \_\_\_\_\_