

FSA Enrollment Form

Employee Name: Social Security #:	EMPLOYEE PROFILE		
Address: City: State: Effective Date: Zip: DEPENDENT CARD I would like a dependent card Yes No My dependent has a card. I would like to link it Yes No to the new plan year account. Dependent Name: Dependent DOB: Social Security #: ELECTION I authorize my employer to reduce my salary by the amount(s) necessary to cover my participation in my company's Flexible Benefits Program as selected below. (Choose one) Weekly: Bi-weekly: Monthly: Annual: Other: Please Explain: Reimbursement Account for Non-Reimbursable Health Care Expenses FSA This includes deductible, co-insurance, eye care, dental care, prescription drugs, routine care, well-baby care, etc. (Maximum Salary reduction contribution that can be allocated to the Health FSA is \$3,300) \$ Reimbursement Account for Dependent Day Care DCA(up to 13 years of age) (Maximum yearly amount is \$5,000 for married individuals filing jointly and single individuals or \$2,500 for married individuals filing separately.). \$ Total \$ AUTHORIZATION • My Employer's benefits have been explained to me and I understand that: I can NOT change or revoke my election UNLESS I have a change in family status (marriage, divorce, death or a spouse or child, birth or adoption of a child, or termination of a spouse's employment) and my employer allows such changes. • The total amount deducted must be used during the Plan year or forfetted under IRS rules. Certain exceptions may apply. • Participation in the Fleakible Benefits Plan may mean that I will be paring less Social Security Tax, which could slightly reduce my social Security tax, which fould slightly reduce my social Security tax, which could slightly reduce my social S	Employee Name:	Social Security #	
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