FLEXIBLE SPENDING/CAFETERIA PLAN ENROLLMENT FORM

EMPLOYER NAME:		PLAN YEAR: 20________		☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER [MUST BE PROVIDED]
EMPLOYEE LAST NAME:			FIRST NAME		M.I.
STREET ADDRESS		CITY		STATE	ZIP CODE
HOME PHONE NUMBER	DATE OF BIRTH	DATE OF HIRE	DIVISION OF COMPANY		☐ SINGLE ☐ FAMILY
E-MAIL ADDRESS					
PAYROLL CYCLE	☐ WEEKLY	☐ BI-WEEKLY	☐ SEMI-MONTHLY	☐ MONTHLY	☐ OTHER
DATE OF FIRST PAYROLL WITHHOLD:		MONTH	DAY	YEAR	

ACCOUNT TYPE NOTE: NOT ALL ACCOUNTS MAY APPLY TO YOUR COMPANY	ELECTION AMOUNT NOTE: NOT ALL ACCOUNTS MAY APPLY TO YOUR COMPANY	SHORT PLAN YEARS / MID-YEAR ENROLLEES [PLEASE NOTE BELOW]
MEDICAL EXPENSE REIMBURSEMENT EXAMPLES: DOCTOR CO-PAYMENTS, EYE GLASSES	________________ ANNUAL	YOUR ELECTION AMOUNT WILL BE THE **FULL AMOUNT** YOU ARE ELECTING EVEN IF YOU WILL NOT BE ENROLLED IN THE PLAN[S] FOR A FULL 12 MONTHS. THIS AMOUNT **WILL NOT** BE PRORATED FOR YOUR SHORT PLAN YEAR.
DEPENDENT CARE ASSISTANCE EXAMPLES: DAYCARE CENTERS, AFTER SCHOOL PROGRAMS, ELDERCARE *Refer to page 16 for dependent care daycare assistance account guidelines.*	________________ ANNUAL	
INDIVIDUAL PREMIUM REIMBURSEMENT	________________ ANNUAL	
ADOPTION ASSISTANCE	________________ ANNUAL	

MINIMUM REIMBURSEMENT AMOUNT FOR PAPER CHECK IS $25

PLEASE NOTE:
For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION
I hereby elect the benefits indicated above. I have read and understand the enrollment materials (FSA brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT: ______________________________ DATE: ____ / ____ / ____

PLEASE RETURN ALL ENROLLMENT FORMS TO YOUR EMPLOYER