EMPLOYEE ENROLLMENT FORM

Flexible Spending Account

I. Participant Information:

Participant's Name | Employer Name

Participant's Home Address

Social Security Number | Birth Date | Home Phone

II. Family Information:

Spouse's Name	Birth Date	Social Security Number
Dependent's Name	Birth Date	Social Security Number
Dependent's Name	Birth Date	Social Security Number
Dependent's Name	Birth Date	Social Security Number
Dependent's Name	Birth Date	Social Security Number

III. Enrollment Information: **(Please check one.)**

☐ Annual open enrollment for the period from _____ to_____

☐ New hire enrollment for the period from _____ to _____

☐ Revised enrollment due to a permitted change for the period from _____ to _____

IV. Benefit Information: **(Please check all that apply.)**

A. Group Insurance Premium Payment (Please check one.)

☐ I hereby authorize my employer to reduce my salary to pay for my portion of the cost for the employer sponsored group health plan on a **pre-tax basis**. I understand that this election may be adjusted from time to time to take into consideration premium increases and coverage changes.

☐ I do not wish to make contributions on a pre-tax basis. I elect to make any contributions from my salary on a post tax basis.

☐ I do not wish to elect coverage for which I am eligible or are not eligible for group coverage

B. Health FSA Benefit: (Please check one.) ☐ Yes ☐ No

If your answer is yes, please indicate the per Pay Period Amount _____ and Annual Amount _____.

C. **Dependent Care FSA Benefit: (Please check one.)** ☐ Yes ☐ No

If your answer is yes, please indicate the Per Pay Period Amount _____ and Annual Amount _____.

V. Authorization and Agreement:

I hereby authorize my employer to adjust my pay as required by my election(s). I understand that the benefit options I have elected above will remain in force throughout the plan year, unless I have incurred one of the events explained in the Summary Plan Description.

_____

Employee Signature Date