

FLEXIBLE SPENDING ACCOUNT

Benefit Enrollment Form

EMPLOYER: _____

EFFECTIVE DATE _____

Pay Cycle (circle one): Weekly Bi-Weekly Semi-Monthly Monthly

1ST DEDUCTION DATE _____

Please indicate the amount to be deducted **per pay period**:

FLEXIBLE SPENDING ACCOUNT TYPE	PAY PERIOD DEDUCTION	ANNUALLY
1. Health Care Spending	\$ _____	\$ _____
2. Dependent Care Spending	\$ _____	\$ _____
TOTAL PRE-TAX DOLLARS	\$ 	\$

No change or revocation of this Participation Agreement can be made at any time during the plan year unless there is a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of spouse's employment and such other events as the administrator determines will permit a change or revocation). Employee understands that changes in the group rates eligible under this plan will be automatically adjusted for the participant's election. The employee agrees on demand to indemnify and reimburse the employer for any liability that may incur from failure to withhold federal and state income tax or social security tax.

I have read the explanation of the Flexible Spending Account program and understand my benefit choices. I authorize the selections I have made as well as the payments required for those selections. I understand the following:

- ◆ *The above selections are effective for the entire year unless I experience a recognized change in status.*
- ◆ *Any money placed into either the Health Care or Dependent Care Spending Accounts and not used by the end of the plan year will be forfeited.*
- ◆ *The amount I have elected to contribute to the Dependent Care Account cannot exceed the amount of my or my spouse's income, whichever is less.*
- ◆ *The Health Care Spending account is a benefit subject to COBRA if my employment is terminated.*
- ◆ *If my annual reimbursements exceed my annual election in error, I agree to reimburse the plan.*

Employee's Name: _____ Employee's SSN: _____

Employee's Address: _____

Employee's City: _____ State: _____ Zip code: _____

Employee's Signature: _____ Date: _____

Employee's Email Address: _____

DECLINATION OF COVERAGE

I hereby acknowledge that I have been given the opportunity to participate in the Flexible Spending Account Plan sponsored by my employer. The benefits have been explained to me and I decline to participate in the program at this time.

Date

Signature