Flexible Benefit Program
Enrollment/Change

☐ New Employee
☐ New Enrollment
☐ Change
☐ Waive Participation

This change is due to: Date of event: ________

☐ Unpaid Leave of absence	☐ Spouse becomes or ceases to be employed	☐ Death of spouse or child
☐ Birth/adoption of a child	☐ Divorce/legal separation	☐ Change in work hours
☐ Marriage	☐ Other	

Please complete entire form. If making a change indicate only employee name, Social Security number, items changed, and sign the form

1 EMPLOYEE INFORMATION

Employee name (Last, first, middle initial)	Employer name
Employee address (street)	Employer location/division Group number
(City, State, Zip Code)	How often are you paid? ☐ Weekly (52/yr) ☐ Bi-Weekly (26/yr) ☐ Semi-monthly (24/yr ☐ Monthly (12/yr) ☐ Other
Social Security Number - -	Date of employment / /
Birthdate / /	Employment status ☐ Full Time ☐ Part Time ☐ Temporary ☐ Other

2 BENEFIT ELECTIONS

Flexible Spending Accounts

Tax Filing Status: If you are married and your spouse files a separate tax return, IRS regulations state you are limited to a $2,500 annua election (pledge) to the dependent care assistance plan.

I request the following amounts to be deducted from my salary with pre-tax dollars:

	Per pay period	Annual Contribution		Per pay period	Annual Contribution
Healthcare spending account	$ ______	$ ______	Dependent Care assistance plar	$ ______	$ ______

I elect to receive my reimbursements by: ☐ Direct Deposit (ACH form required) ☐ Check ☐ Debit Card (Annual fee of $29.95 applies)

3 AUTHORIZATION OR DECLINATION OF PARTICIPATION

Signature and acknowledgement: I request the coverage and classifications listed above and I authorize payroll deductions for these coverages. I understand that my election(s) to either participate or waive coverage is binding for the plan year and the deduction(s), if any, will be in effect for the entire plan year and cannot be revoked unless provided for under the provisions of the plan. I hereby certify the above information to be true to the best of my knowledge and the dependents for whom I will be claiming dependent care and expenses are eligible as my dependents for tax purposes. I further understand future Social Security benefits may be affected should I elect pre-tax salary reduction.

Employer's signature

X ______________________ Date ______

Employer's use only

Effective date of change: First payroll deduction date

Plan administrator's signature

X ______________________ Date ______