



Participant Information

Employer _____ Employee Name: _____
 Employee SS# _____ Date of Birth _____
mm/dd/yyyy
 Address _____ City _____ State _____ ZIP Code _____
 Day Telephone () _____
 Pay Frequency (Please describe): _____
 E-mail Address* _____ Hire Date _____ Hours Worked/Week _____
*E-mail address is mandatory, account access is provided to participants through this address.
 Gender: Male / Female Marital Status: Married / Single

Enrollment

Cause for Enrollment: Open Enrollment New Hire Status Change (marriage/birth/divorce/death)

	FSA (Medical) Limit set by employer	FSA (Dependent Care) Limit set by employer up to IRS max of \$5,000	Total
Annual Election <small>(cannot exceed employer's specified amount)</small>	\$ _____	\$ _____	\$ _____
Number of Pay Periods	-----		÷
Amount Deducted per Pay Period	-----		=
Date of First Payroll	_____		
<small>mm/dd/yyyy</small>			
Participant Effective Date	_____		
<small>mm/dd/yyyy</small>			

To calculate per paycheck deduction divide annual election by number of pay periods

Participant Banking Information

Bank Name _____ Account Type Checking Savings
 Street Address _____ City _____ State _____ ZIP _____
 Routing Number _____
 Account Number _____

(This account information is used so that claim repayments can be made by direct deposit. If Banking information is not provided then repayments for items not purchased with the benefit debit card will be made via a paper check, mailed to the participant address listed in section one.)

Routing Number Account Number

Participant Authorization

Accept: I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with the Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account

Decline: I do not want to participate. I understand that by refusing to participate, I will be unable to enroll this plan year unless I experience a qualifying event in accordance with the Internal Revenue Code Section 125 and submit the change within a reasonable amount of time as deemed by the IRS and my employer

Participant Signature: _____ Date: _____

Employer Signature: _____ Date: _____