

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM PAYROLL DEDUCTION AUTHORIZATION

Employer Name			Plan Number			
Please check one:	New Enro Waiver of			nily Status Change Effective Date		
Employee Inform	ation					
Full Name			ID#			
Tairranio				10 11		
Address				Date of Birth		
City, State, Zip				Home Phone # (include area code)		
Election Information Health Care Account I would like to enroll in the Health Care Spending Account I do not wish to enroll in the Health Care Account I wish to deposit the following amount on a pre-tax basis to the Health Care Spending Account						
Deduction per pay period Number of Dedu			ductions	Annual	Annual Election	
Dependent Care Account I would like to enroll in the Dep Care Spending Account I do not wish to enroll in the Dep Care Account I wish to deposit the following amount on a pre-tax basis to the Dependent Care Spending Account						
Deduction per pay p	eriod	Number of Dec	ductions	Annual	Election	
Waiver of Election I do not wish to enroll in either the Health Care Spending Account or the Dependent Care Spending Account; however, I authorize my employer to withhold the required contributions for my Group Health Premiums. These required contributions will be pre-tax contributions and I understand that I cannot change or revoke my contributions before the next anniversary date of the plan unless I have a qualified family status change. Employee Signature: Date:						
Employed dignature.			Date.			
Lunderstand that my a	nnual contrib	utions can only bo	used to reimbu	Irea avnence	under each account and	
I understand that my annual contributions can only be used to reimburse expenses under each account and that I will forfeit any funds remaining in my account at the end of the plan year/grace period. I understand that I cannot change or revoke my contributions before the next anniversary date of the plan unless I have a						

qualified family status change. My signature certifies that I authorize pre-tax payroll deductions as contributions to my health and/or dependent care accounts as indicated above and for the required

Date:

contributions for my Group Health Premiums.

Employee Signature: