



**SECTION 125
FLEXIBLE
SPENDING**

EMPLOYEE ENROLLMENT FORM

Employer		Division		Effective Date	
Employee's Name (Last, First, Middle)			Social Security Number		
Occupation	Hours regularly worked each month for this employer		Date Employed Month	Day	Year
Street Address		City	State	Zip Code	

Date of Birth Month Day Year		Check One <input type="radio"/> Male <input type="radio"/> Female	Check One <input type="radio"/> Married <input type="radio"/> Single	<input type="radio"/> Widowed <input type="radio"/> Divorced	Dependent Health Coverage <input type="radio"/> Yes <input type="radio"/> No
Spouse Name (First, M.I.)		Date of Birth Month Day Year		I request that my salary be reduced as follows: Health Flexible Spending Account (Amount per pay period) \$ _____ Total Annual HFSA Pledge \$ _____ Dependent Care Spending Account (Amount per pay period) \$ _____ Total Annual DFSA Pledge \$ _____	
Dependent Name (First, M.I.)		Date of Birth Month Day Year			
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Dependent Name (First, M.I.)		Date of Birth Month Day Year			

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and that the children listed under "Dependent Coverage" either reside with me in a parent- child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signature _____ Date _____

Must Be Completed by Employer

Annual Enrollment New Hire Change in Family Status

HFSA _____ Payroll Date of 1st Deduction x _____ # of remaining pay periods left for plan year. - _____ Annual Pledge	DFSA _____ Payroll Date of 1st Deduction x _____ # of remaining pay periods left for plan year. - _____ Annual Pledge
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IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline to participate.

Signature _____ Date _____