

Employee Signature

Please return this form to your Em	ployer:			
Enrollment Form: Flexible S	Spending Acc	ount(s)		
		Pla	an Start Dat	e – Plan End Date
GENERAL INFORMATION				_
Employee Name:				
Mailing Address:				
City, State:				
E-mail Address:		Date of H	lire:	
FLEXIBLE SPENDING ACCOUNTS				
☐ I elect to participate in the Flexible Sp☐ I elect to participate in the Flexible Sp☐ I elect to participate in the employer-s☐ I do not wish to participate in the Flex	ending Accounts onl ponsored benefit co- ible Spending Accou	y. verage only. ints or employe	er-sponsored	benefit coverage.
Max Amount	Per Pay Period	•		Annual Election
Health Care FSA				
Dependent Care FSA (Day care expenses incurred during employment ho		x	= \$	
AUTHORIZATION & ACKNOWLEDGEN I understand that I cannot revoke or ch "Change in Status" event that affects my The rules regarding election changes an	range this election of or my dependents' e re described in more	eligibility under e detail in the	this Plan or a Summary Pl	nother employer plan. an Description. I also
understand that if I or my spouse partici under the Health Care Reimbursement Ad I understand that I must submit a claim shill) for out-of-pocket, Medical, Dental, V certify that I will only submit claims for expenses incurred by myself or my eligib Spending Account Plan. I certify that I was already.	ccount may be limite and appropriate doc ision and/or Depend r reimbursement un le dependents, in ac vill not submit claims	d. umentation (e. ent Care expe der the Flexil cordance with s for reimburse	g. explanation enses before lole Spending the terms of the terms of th	n of benefits, itemized can be reimbursed. Accounts for eligible the respective Flexible the Flexible Spending
Accounts for amounts that have already such amounts from any other source.	been reimbursed by	anomer sourc	E HOLWIILESE	tek reimbursement i

Date