

# Health/Dependent Care Flexible Spending Account Enrollment Form



This form is designed to be completed by using your computer and tabbing through the designated fields. If completing a printed copy by hand, please use black or blue ink, print clearly, and only in spaces provided.

Social Security Number \_\_\_\_\_

\_\_\_\_\_  
 First Name M.I. Last Name

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City State

\_\_\_\_\_  
 Zip Code Day Phone

\_\_\_\_\_  
 Email

*Need help deciding how much to elect or how much you will save using a Flexible Spending Account?*

*VISIT OUR WEBSITE at [www.flexdirect.adp.com](http://www.flexdirect.adp.com)*

I have reviewed the terms of my employer's Plan and I understand that I may elect coverage under either or both of the accounts below, subject to the terms of the Plan, for the Plan Year \_\_\_\_\_.

CHILD/ELDERLY CARE FLEXIBLE SPENDING ACCOUNT	CONTRIBUTION PER PAY PERIOD \$ _____	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR X _____	= _____	YOUR ANNUAL ELECTION AMOUNT _____ <small>CANNOT EXCEED \$5,000 PER HOUSEHOLD</small>
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HEALTH CARE FLEXIBLE SPENDING ACCOUNT	CONTRIBUTION PER PAY PERIOD \$ _____	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR X _____	= _____	YOUR ANNUAL ELECTION AMOUNT _____
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I elect to participate in employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. ***Any salary deductions that have not been used for expenses incurred in the Current Plan Year noted above will be forfeited.***

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from my wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Date