

FSA ENROLLMENT FORM

PLEASE PRINT CLEARLY. USE ALL CAPITAL LETTERS

GENERAL INFORMATION

Group _____

Plan ID _____ PID or SSN _____

Name _____
First Last

Address _____

City _____ State _____ Zip _____ - _____

Phone _____ E-mail _____

Pay Frequency Weekly Bi-Weekly Semi-Monthly Monthly

Effective Date _____

All enrollment elections made on this form are effective for the plan year beginning _____ and ending _____. No changes can be made to these elections once the plan year has begun unless you experience a family status change event. See your enrollment booklet for a list of these events. Return the completed form to your Human Resources department.

For Assistance Call 1-800-532-3327

HEALTH CARE FLEXIBLE SPENDING ACCOUNT INFORMATION

Minimum Annual Contribution _____ Maximum Annual Contribution _____

In the spaces provided below, indicate the amount you wish to contribute to the Medical Spending Account for the year and the amount to be deducted from each paycheck. Note: If your annual election does not equal your paycheck deduction multiplied by the number of pay periods left in the plan year, then your paycheck deduction amount will be adjusted accordingly.

Your Annual Election _____ Your Paycheck Deduction _____

DEPENDENT CARE SPENDING ACCOUNT INFORMATION

Minimum Annual Contribution _____ Maximum Annual Contribution _____

In the spaces provided below, indicate the amount you wish to contribute to the Medical Spending Account for the year and the amount to be deducted from each paycheck. Note: If your annual election does not equal your paycheck deduction multiplied by the number of pay periods left in the plan year, then your paycheck deduction amount will be adjusted accordingly.

Your Annual Election _____ Your Paycheck Deduction _____

LIMITED FSA ENROLLMENT

Please indicate if your Health Care FSA Election should be Limited to Dental and Vision:

Yes, Limit my FSA

No, I am electing a Full Medical FSA and will not be contributing to an HSA

PAYROLL AUTHORIZATION

I have read The Summary Plan Description provided by the above-mentioned employer and hereby choose to participate as shown above. I agree to a per pay period reduction during the plan year referenced above for the amounts indicated. I understand that this election is binding for the plan year and that changes are only permitted in case of a change in family status or spouse's employment.

Employee Signature (Void if not signed)

Date