Participant Information

Employer Name: _____ **Employer/Location:** _____

Employee Name: _____ _____ _____
(First Name) (Middle Initial) (Last Name)

SSN/EEID: _____ **Date of Birth:** _____

Current Address: _____
(Street Address)

_____
(Floor or Apt No.)

_____
(City, State Zip)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately

Phone Number: _____ _____
Phone Number EMAIL ADDRESS

Health Care Spending Account:

The Health Care Spending Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

☐ **Yes, I want to participate**
☐ **No, I do not want to participate**

$ _____ ÷ _____ = $ _____

Plan Year Contribution | **# Pay Periods in the Plan Year** | **Pay Period Pre-Tax Contribution**

Dependent Care Spending Account:

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you or your spouse (if applicable) to work or attend school on a full-time basis.

☐ **Yes, I want to participate**
☐ **No, I do not want to participate**

$ _____ ÷ _____ = $ _____

Plan Year Contribution Max of $5,000 ($2,500 if filing taxes separate) | **# Pay Periods in the Plan Year** | **Pay Period Pre-Tax Contribution**

I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware that I have a grace period in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a status change and that I may experience future reductions in life, disability and Social Security benefits by participating in this Flexible Spending Plan.

PLEASE SUBMIT THIS COMPLETED FORM TO BENEFITS COORDINATOR. LATE ENROLLMENTS WILL NOT BE ACCEPTED.

Participant Signature _____ **Date** _____