



Flexible Spending Account / Cafeteria Plan Enrollment / Change Form

Employer Name: _____

Last Name: _____ First Name: _____ M.I. _____ Male Female

Email Address _____ Social Security Number (must be provided) _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Date of Birth _____ Date of Hire _____

Payroll Cycle: Weekly Bi-Weekly Semi-Monthly Monthly Other _____

Date of first payroll withhold: Month _____ Day _____ Year _____

Spouse Name (First, M.I., Last)	Date of Birth	Spouse Social Security Number:
Dependent Name (First, M.I., Last)	Date of Birth / Gender	Dependent Social Security Number:
Dependent Name (First, M.I., Last)	Date of Birth / Gender	Dependent Social Security Number:

Plan Year Dates: From ___/___/___ to ___/___/___

Account Type (Note: Not all accounts may Apply to your company)	"Plan Year" Election Amount	New/Change? (Changes must accompany change Report from employer)
FSA - Medical Expense Reimbursement (Ex: Doctor co-payments, Prescriptions, OTC meds, Vision, Dental Expenses)	\$ _____ Plan Year \$ _____ Per Pay	<input type="checkbox"/> New <input type="checkbox"/> Change
Dependent Care Assistance (Ex: Child Day Care) (*See Note Below)	\$ _____ Plan Year \$ _____ Per Pay	<input type="checkbox"/> New <input type="checkbox"/> Change

Cafeteria Plan Election Statement:

- I elect to have my FSA Election Amount Dollars deducted from my pay on a pre-tax basis.
- I **do not** wish to have my FSA Election Amount Dollars deducted from my pay on a pre-tax basis.

***Year-End Tax Credit may produce greater savings than paying for DCAP FSA benefits with pre-tax salary reduction contributions. (Consult your Tax Advisor if unsure.)**

Please note: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION : I hereby elect the benefits indicated above. I have read and understood the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT _____ Date _____

**For questions, please contact:
Dawn Montoya at Dmontoya@adminusa.us or 252-293-7829**