

# 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 the 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 \_\_\_\_\_.

<b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b>	CONTRIBUTION PER PAY PERIOD \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR X <input type="text"/> <input type="text"/>	= <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	YOUR ANNUAL ELECTION AMOUNT CANNOT EXCEED \$5,000 PER HOUSEHOLD
<b>HEALTH CARE FLEXIBLE SPENDING ACCOUNT</b>	CONTRIBUTION PER PAY PERIOD \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR X <input type="text"/> <input type="text"/>	= <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	YOUR ANNUAL ELECTION AMOUNT

I elect to participate in my 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 wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Employer Section: ADP FSA Client ID \_\_\_\_\_ Employee ADP Company Code \_\_\_\_\_ Effective Date of Employee Election \_\_\_\_\_