HEALTHEZ®

FSA Enrollment Form

Employee Information (required)

First Name:	MI:	Last Name:		
SSN#:	Date of Birth:			
Address:		City:	State:	Zip:
Daytime Phone: ( )	Home phone: ( )		Email:	

Flexible Spending Accounts

I understand that:

- I cannot change Flexible Spending Account deductions during the Plan Year unless I have a change in family status.
- Any amounts remaining in my Flexible Spending Account at the end of the Plan Year, after all claims have been processed, will be forfeited.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections, and will terminate on the earlier of: (1) the end of the Plan Year, (2) when I am no longer a qualified employee eligible to participate in the Plan, or (3) termination of the Plan
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I authorize my employer to make the following salary reductions:

Effective Date: _____

Flexible Spending Health Care Reimbursement Account:
I elect to have $_____ annually ($2,650 maximum)

Number of Pay Periods :26
Per Pay Period Deduction _____

Dependent Care Reimbursement Account:
I elect to have $_____ annually ($5,000 maximum)

Number of Pay Periods: 26
Per Pay Period Deduction _____

I understand that by signing this Enrollment Form I am authorizing any necessary pre-tax deductions required to pay for above elected benefit selections.

_____

Employee Signature Date