

**Flexible Spending Account Enrollment Form**  
**Plan Year – 01/01/2009 – 12/31/2009**

**Section 1 – Employee Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 First Time Enrollment  Re-Enrollment  Address Change  Gender:  Male  Female

**Section 2 – Benefit Description**

Unreimbursed Medical Account \_\_\_\_\_ Per Pay Period Amount \_\_\_\_\_ Annual Deduction Amount \_\_\_\_\_  
 Dependent Care Reimbursement Account \_\_\_\_\_

**Section 3 – Spouse & Dependent(s) Information:** (Include only those dependents you will be including on your Federal Income Tax Return)

	Spouse & Dependent(s) Name	Social Security Number	Date of Birth	Relationship
A				
B				
C				
D				

**Section 4 – Signature**

I certify I will have the above total amount deducted from each of my paychecks. I understand this will lower my gross pay, and consequently, my tax base and my Social Security base. I also understand that I cannot make any changes during the plan unless I experience a change in family status. In addition, I certify that if I am issued a debit card with this benefit, I will only use it for eligible medical and/or dependent care expenses as defined by the IRS under Section 213 and/or section 21 for my spouse, dependents, and myself. I also certify any expense paid using such debit card has not been reimbursed by any other plan covering health benefits, nor will I seek reimbursement under any other plan or deduct such expenses on my income tax return. I understand this certification is reaffirmed each time the card is used and I agree to acquire and retain sufficient documentation for any expense paid with the card, and submit such documentation as substantiation when requested.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

**Employer Use Only**

Open enrollment  New Hire  Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ First Payroll Deduction Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dept/Division: \_\_\_\_\_  
 Administrator Initials: \_\_\_\_\_ Date: \_\_\_\_\_