Please return this form to your human resources representative.

Flexible Spending Account Enrollment Form

Personal Information

Employer: ______________________________

Full Name: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: (   ) ______________ Alternate Phone: (   ) ______________

E-mail Address: ______________________________

Social Security Number: ______________________________

Birth Date: ______________ Effective Date: ______________

Signature: ______________________________

Date: Plan Year Start:

Benefit Election

Date of First Deduction: ______________ Number of Remaining Pays ______

Medical FSA Annual Election: ______________ Per Pay: ______________

Dependent Care Annual Election: ______________ Per Pay: ______________

Direct Deposit Information

- By signing this form I agree that my cash compensation will be redirected by the amounts set forth above.
- If you do not return this form to your employer by your effective date you will not be able to participate in the plan until the following plan year.
- You must sign a new election form each year at open enrollment, your accounts will not automatically renew.
- You cannot change this election during the plan year unless you have an eligible change in status.
- This agreement is subject to the terms of the company's Flexible Benefits Plan.
- By completing the Direct Deposit Section and signing I authorize Flex Facts to initiate debits and/or credits to or from my bank account indicated above. Debits will only be initiated in order to correct a prior reimbursement error.

___ I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.

Signature: ______________________________