Flexible Spending Account Enrollment Application

1. Employee Information

Last Name _____ First _____ Initial _____
Social Security Number _____ Date of Hire/Rehire _____
Address _____ City _____ State _____ Zip _____
Phone _____ Date of Birth _____
Employer _____ Employer Location _____

2. Spouse Information

Last Name _____ First _____ Initial _____
Spouse Employer _____
Is your Spouse now participating in Flexible Benefits? ☐ Yes ☐ No
Is your Spouse eligible for other Group Health Benefits? ☐ Yes ☐ No

Please select one of the following two options and insert dates

☐ OPTION ONE:

I hereby elect the coverages and benefits indicated below for the period of coverage from _____ to _____.

Please mark the number of Pay Periods* you have in one year: ☐ 26 ☐ 52

HEALTH CARE REIMBURSEMENT ELECTION**

The amount I elect to have deducted from my paycheck each pay period for this expense account is $ _____
Pay Period Contribution x Number of Pay Periods in the Year / Annual Pledge = $ _____

DEPENDENT CARE REIMBURSEMENT ELECTION

The amount I elect to have deducted from my paycheck each pay period for this expense account is $ _____
Pay Period Contribution x Number of Pay Periods in the Year / Annual Pledge = $ _____

☐ OPTION TWO:

I waive participation in the Health Care and Dependent Care Flexible Spending Account Program at this time. I understand unless I qualify for a change in lifestyle status, the next election period is from _____ to _____.

Employee Signature _____ **Date** _____

Note: To calculate your annual pledge, multiply your pay period contributions times the number of pay periods in the year.*
EXAMPLE: $10.00 CONTRIBUTION
Example #1-- WEEKLY-- $10.00 X 52* = $520.00 annual pledge Example #2--Bi-WEELY-- $10.00 X 26* =$260.00 annual pledge

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**I understand that:
Reimbursements will be available only for "qualifying medical care expenses." Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued.

If I cease my employment with the Employer, my participation in the Plan will cease. No further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursements for claims incurred prior to my date of termination.

I cannot seek reimbursement from this account for a medical expense that I intend on taking as a deduction or credit on my tax return.

Employee Signature _____ **Date** _____

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ABS Automated Benefit Services