Flexible Spending Account / Cafeteria Plan
Enrollment and Change Form

Employer Name ____

Last Name_______________________ First Name ____________ M.I.________ ☐ Male ☐ Female

Email Address________________________ Social Security # (must be provided) __________________

Street Address _______________________ City _______________ State ______ Zip Code _______

Home Phone Number ____________________ Date of Birth __________ Date of Hire____________

Division of Company ______________________________________ ☐ Single ☐ Family

Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other __________________
Date of first payroll withhold: Month ________ Day ___________ Year _____________

Spouse Name (First, M.I., Last)	Date of Birth	Dependent Name (First, M.I., Last)	Date of Birth / Gender
Dependent Name (First, M.I., Last)	Date of Birth / Gender	Dependent Name (First, M.I., Last)	Date of Birth / Gender
Dependent Name (First, M.I., Last)	Date of Birth / Gender	Dependent Name (First, M.I., Last)	Date of Birth / Gender

Plan Year Dates: From _____/_____/_____ to _____/_____/_____

Account Type (Note: Not all accounts may apply to your company)	**“Plan Year” Election Amount**	**New/Change?** (Changes must accompany change report from employer)
Medical Expense Reimbursement (Ex: Doctor co-payments, Prescriptions, OTC meds, Vision, Dental Expenses)	$________ Plan Year = $________ Per Pay	☐ New ☐ Change
Dependent Care Assistance (Ex: Child Day Care) (*See Note Below)	$ _______ Plan Year = $ _______ Per Pay	☐ New ☐ Change

Cafeteria Plan Election Statement:
☐ I elect to have my FSA Election Amount Dollars deducted from my pay on a pre-tax basis.
☐ I **do not** wish to have my FSA Election Amount Dollars deducted from my pay on a pre-tax basis.

***Year-End Tax Credit may produce greater savings than paying for DCAP FSA benefits with pre-tax salary reduction contributions. (Consult your Tax Advisor if unsure.)**

Please note: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION : I hereby elect the benefits indicated above. I have read and understood the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used fro eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT ______________________________________ Date_____________