

Flex Facts Enrollment Form

Please return this form to your human resources representative

Personal Information

Employer: _____

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Social Security Number: _____

Birth Date: _____ E-mail Address: _____

Effective Date: _____ Plan Year Start: _____

Benefit Election

I ELECT THE FOLLOWING:	Amount Per Pay Period	# of Pay Periods	Annual Election
Medical FSA Account	\$ _____	_____	\$ _____
Dependent Care Account	\$ _____	_____	\$ _____
Limited Purpose FSA (HSA only)	\$ _____	_____	\$ _____

Frequency of Pay: Weekly Bi-Weekly Semi-Monthly Monthly Other

Date of First Deduction: _____

Spouse or Dependent Card Information

Full Name: _____
Last First M.I.

Mail Card to: Address listed above Alternate Address: _____
Street Address Apt. /Unit #

Date of Birth: _____
City State ZIP Code

Soc. Sec. Number: _____ Relationship: _____

Employee Authorization

- If this form is not returned to your employer by your effective date, you will not be able to participate in the plan until the following plan year.
- Your accounts will not automatically renew. You must sign a new election form each year at open enrollment.
- You cannot change the FSA 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 signing this form, I agree that my cash compensation will be redirected by the amounts set forth above.

Signature: _____ Date: _____