

Employer Use Only								
Re-enrollment	N	ew _		Cha	inge			
Effective Date								
1st Deduction [Date							
Payroll Mode	W	В	S	М	Q			
Division Code								

Health Care and Dependent Care Flexible Spending Accounts Enrollment Form

i. Personal information (Please prin	it clearly and prov	/ide complete	and accura	ate intorn	nation.)							
Your Employer:												
Member #	Your Nam	e										
(This may be your SSN or employer assigned num	(This may be your SSN or employer assigned number) (Last)				(Fir		rst)	(MI)				
Address	City				State	_ Zip						
☐ Check if this address is new within last year.	Date of Birth _	/_	/_		Hire Date _		_/	/				
II. Election Information (Please chec	k the appropriate	box to indica	te if you wi	sh to enr	oll, or do not wish t	o enro	II, and sign be	elow.)				
Yes, I wish to participate in the flexible spendi below, and continuing until this election is an automatically reduced from my compensation of I have been offered the opportunity to enroll in benefit coverage contributions are automatically BENEFIT CHOICES	nended or termina on a pre-tax basis. on the flexible spend	ited or until the	e Plan Yea lan and do on a pre-ta	r ends.	Employer-sponsored	benef	it coverage co	ntributions are				
		AMOUNT			PAY PERIODS							
 The minimum and/or maximum contribution amo determined by your employer. 	ounts are	\$	•	_ X		=	\$	•				
 Dependent Day Care Flexible Spending The minimum contribution amount is determined employer; however the maximum contribution are is set by the IRS. If married, and your spouse is disabled, a full-time earns less than you, lower limits may apply. Ple IRS guidelines for further information. 	by your nount of \$5,000 ne student or	\$		_ X		=	\$	•				
I understand that: This election can only be changed or revoked don't he new election must be consistent with my employer. This election will be automatically changed or sponsored benefit contributions increase or decreated to the maximum exclusion under a Dependent Condition individuals filing separately will get a lower exclusion. Any amounts remaining in my reimbursement according to the following separately will get a lower exclusion. Anew Enrollment Form must be completed expoportunity to participate in the Benefit Choices of Social Security and Medicare taxes are not being the amount of salary reductions may not be clained. If my employment terminates, only medical expension of the payFlex Debit Card, I agree to use the cardholder statement I receive with the card and employment. Any expenses I pay for with the PayFlex Debit C	change in status, cancelled, if necesease. are Reimbursemersion (\$2,500 per cancents at the endount cannot be transpach Plan Year. If putlined above, by withheld on the amed on my or my somes incurred through a see incurred through a card for eligible d I understand the lard or for which I cancelled.	must be applicessary, to connect Account for alendar year). of the Plan Yeasferred and use I do not commount of my sepouse's incomugh my period of substantiation expenses only a card is subjectalism reimburse	ed for within ply with property with property with property with property with property with property and retain property with p	rovisions of dividuals fit 441 must feited. uses in any return an ion under as. e as define ents and I all itemize ation if I contained to thave be	of the Internal Reversion of the Internal Re	d is sultenue C \$5,000 sonal in uring C consideragree ts. I ag ne prove thave re-	ode or if requi oper calendar come tax return open Enrollmer dered for reimboto, provide doc ree to read and risions or upon	pproval by my ired employer- year. Married in. Int, I forfeit the ursement. Eumentation as adhere to the termination of where.				
III. Pre-Authorization for Direct I	Deposit (If you	u are already e	enrolled in	direct de	posit or do not wish	n to, ig	nore this secti	ion.)				
☐ I authorize PayFlex Systems USA, Inc. to initial effect until written notification is supplied by APPLICATION	te a credit and/or on the to PayFlex ter	debit entry to m minating this	y account fagreement.	or my Pay A "VOID	Flex reimbursement	s. This	agreement is to	o remain in full				
Signature					Date			Rev. 8-12				