

**FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM**

**EMPLOYER/EMPLOYEE INFORMATION**

Group Name _____	Employer Number _____	Plan Year: 01/01/2008 through 12/31/2008
Employee Social Security Number: _____ Employee Number: _____		
Employee Name: _____ (Last, First, MI)		
Home Address: _____ _____, _____ - _____ (City) (St) (Zip)		
Daytime Phone Number (____) _____ - _____ Date of Birth: _____		
Location _____ Payroll Frequency: _____		
Effective Date: _____ (To Be Provided by Group Contact)		

**(II) ELECTIONS**

**Medical Flexible Spending Account**

I want to contribute a total of \$ \_\_\_\_\_ during this Plan Year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

**Dependent Care Flexible Spending Account**

Plan Year Maximum of \$5,000.00 (\$2,500.00 if married but filing separate tax returns)

I want to contribute a total of \$ \_\_\_\_\_ during this Plan Year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date