FLEXIBLE SPENDING ACCOUNT
CALENDAR YEAR 20_____
ENROLLMENT FORM

☐ Salaried
☐ Bargaining Unit

Emp ID: ________________ Employee Name: ______________________________ Birth Date: ________________

Enrollment Election Information:

I elect to have my taxable earnings reduced and to have the amount(s) contributed on a before-tax basis to my **20___ (year)** Flexible Spending Account(s), as follows:

Medical and Dental Reimbursement Account

Amount of Reduction Per Year

$________________ (Annual Amount)

Note: Maximum Contributions of $3,000.00 Per Year
Minimum Contributions of $250.00 Per Year

If you do not elect Medical and Dental Reimbursement but do elect the Dependent Child Care Reimbursement, please fill in the Medical and Dental Reimbursement Enrollment amount with zeroes.

Dependent Child Care Reimbursement Account

Amount of Reduction Per Year

$________________ (Annual Amount)

Note: Maximum Contributions of $5,000.00 Per Year
Minimum Contributions of $250.00 Per Year

If you do not elect Dependent Child Care Reimbursement but do elect the Medical and Dental Reimbursement, please fill in the Dependent Child Care Reimbursement Enrollment amount with zeroes.

The amounts indicated on the Enrollment/Change Form are ANNUAL amounts you wish to contribute. The amount(s) will be divided by the number of pay periods in the plan year during the time you are enrolled in the plan.

I understand this enrollment is for the calendar year **20___** enrollment period, and these election(s) cannot be changed unless a change in family status occurs. I also acknowledge I have reviewed the guidelines of the Flexible Spending Account Program and understand the restrictions on expenses that will qualify for reimbursement, as well as the penalty for not applying for reimbursement of amounts contributed.

Employee's Signature: ______________________________ Date: ________________

Please return completed form to your Human Resources Assistant.