# Dependent Care
# Flexible Spending Account
# Enrollment/Change Form

☐ **INITIAL ELECTION** ☐ **CHANGE** ☐ **TERMINATION**

| **EMPLOYEE INFORMATION** | | | |
|---|---|---|---|
| EMPLOYEE SOCIAL SECURITY NO. *(Required)* | EMPLOYER NAME *(Required)* | | |
| EMPLOYEE LAST NAME | EMPLOYEE FIRST NAME | M.I. | DATE OF BIRTH |
| EMPLOYEE ADDRESS | | | |
| CITY | | STATE | ZIP/POSTAL CODE |

## PRE-TAX FLEXIBLE SPENDING ACCOUNT

Choose the annual amount you would like to have withheld from your salary and placed into a Dependent Care Flexible Spending Account for reimbursement of eligible dependent care expenses.

Annual Amount Elected:
**$** ____________________
*(not a per pay period amount)*

**Annual amount elected will be divided by the number of pay periods in the Plan Year.**

## AUTHORIZATION

I hereby authorize my employer to reduce my earnings by the amount stated above for deposit into my Dependent Care Flexible Spending Account and to make this money available to me for the reimbursement of dependent care out-of-pocket expenses as appropriate.

I understand that I will forfeit any unused balance in my account at the end of the Plan Year. I also understand that I cannot change my plan participation during the Plan Year unless I have a change in family status, as defined in the Regulations under Internal Revenue Code Section 125.

| SIGNATURE | DATE |
|---|---|
| | |

| **FOR EMPLOYER USE ONLY** ***(Required)*** | | | | |
|---|---|---|---|---|
| EFFECTIVE DATE | ACCOUNT NUMBER | BRANCH NAME | BRANCH CODE | ER AAE |
| | | | | |

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