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)	$ _____	_____	$ _____
☐ Transit Account	**Monthly Election:** $_____		
☐ Parking Account	**Monthly Election:** $_____		

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: _____