Insight
Benefit Administrators

FLEXIBLE SPENDING ENROLLMENT FORM

(PLEASE PRINT CLEARLY)

Employer Name:_____ **Division:**_____

_____
Employee Last Name | First Name | M.I. | Gender

_____
Employee Street Address | City | State | Zip

_____
Employee SSN # | Date of Birth

Dependents:

DEPENDENT NAME	DEPENDENT SOCIAL SECURITY NUMBER	DEPENDENT DATE OF BIRTH

Health Flexible Spending Account

Per Pay Deduction $ _____

Annual Pledge $ _____

Dependent Care Expense Account

Per Pay Deduction $ _____

Annual Pledge $ _____

Funds will be accounted for separately and cannot be interchanged

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and IRS regulations. I further understand that the Flexible Spending Account deduction(s) will be in effect for the plan year and cannot be revoked unless I experience an eligible change of status as defined under the terms of my employer's plan.

Signature: _____ Date:_____

DECLINATION OF PARTICIPATION: I have been given the opportunity to participate in the above plan and have elected not to do so. I understand that I will not be given another opportunity to enroll until the next plan anniversary date.

Signature: _____ Date: _____

INFORMATION SUPPLIED BY EMPLOYER:

Payroll Frequency:

_____Weekly _____Bi-Weekly _____Other Date of First Deduction: _____ EFF DATE:_____ HIRE DATE:_____

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