



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

Dependent Care Expense Account

Per Pay Deduction \$ _____

Per Pay Deduction \$ _____

Annual Pledge \$ _____

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: _____