



Premium, Medical and Dependent Care Reimbursement Enrollment Form

Please PRINT Clearly

Employer	Plan Effective Date	No. of Payroll Deductions From Eff Date to End of Plan Year
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Employee's First	MI	Last Name	Social Security Number
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Employee's Home Address Street	City	State	Zip	Home Phone
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BirthDate	Sex	Marital Status	Spouse's Name	Employment Date
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I request the following amounts to be deducted pretax:

A. Group Medical Premiums – if you participate in your employer's insurance plan(s), your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department:

Medical Single ____ or Family ____
 Dental Single ____ or Family ____

B. Health FSA: Plan year total _____, Per paycheck _____

_____ No, I do not wish to participate in the healthcare reimbursement account.

C. Dependent Care FSA: Plan year total _____, Per paycheck _____

_____ No, I do not wish to participate in the dependent care reimbursement account.

The IRS regulation states four conditions. 1.) Any expenses you incur must be within the plan year. 2.) Any expenses you incur must not be covered by any other source, such as insurance. 3.) You must provide proper documentation in order to receive payment. 4.) You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. Please see the Summary Plan Description.

Please automatically transfer any unreimbursed medical and/or dental insurance plan claims directly to my Health FSA account. Check one: ____ Yes ____ No

Signature: _____ Date: _____