FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

Employee Name: (please print) ____ SS#____________________

Address: ____Date of Birth: ____________________

City: ____________________State:__________________Zip:_____________________ ☐ Check here if new address

E-mail Address____ Phone: _____________________________________

Date of Hire_________________ Pay Periods__________ Loc/Dept.Code____________________

A	B	C	D	E
Type of FSA Reimbursement Account	**Annual Maximum**	**Annual Election**	**Number of Yearly Pay Periods**	**Deduction Per Pay Period (= C divided by D)**
Healthcare	$			
Dependent Care	*Married Filing Joint or Single: **$5000 Maximum Allowable** *Married filing separate return: **$2500 Maximum Allowable**			
Parking	$			
Transit	$			
Adoption Assistance	$			
Total	**$**			

I understand that reimbursement will be available only for qualifying health care expenses as defined in Section 213 of the Internal Revenue Code or qualifying dependent care expenses. I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

I understand that:

- I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he or she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- I understand that my participation in the Dependent Care Plan reduces my eligibility for the Federal Child Care Tax Credit.
- I understand that my participation in this plan may reduce my Social Security benefits slightly as a result of my election.

Signature of Employee ____ Date ____________________

My signature authorizes my employer to make payroll deductions on a pre-tax basis in agreement with the plan benefits elected above.

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WAIVER OF PARTICIPATION

I understand that I have met all of the eligibility requirements for participation in the above named plan; however, I do not wish to participate at this time. I understand that this refusal will become effective on the first day of the Plan Year. I understand that participation in the Flexible Benefit Plan will not be available to me until next Plan Year and no other benefit is available to me from the above named Plan. I understand that this refusal in no way effects any Employer contributions that may be made to any other Plan sponsored by the Employer.

(Signature of Employee) **(Date)**