Enrollment Form: Flexible Spending Account(s)

GENERAL INFORMATION: **01/01/2018 – 12/31/2018**

Employee Name:	**«First_Name» «Last_Name»**				
Mailing Address:	**«address1» «address2»**				
City:	**«city»**	State:	«State»	Zip:	**«ZipCode»**
E-mail Address:	«Email_Addressif_no_NA»				
Social Security Number:	«SSN_Masked»	Date of Birth:	**«birthday»**		
Date of Hire:	**«Hire_Date»**				

FLEXIBLE SPENDING ACCOUNTS:

I hereby elect to participate in the Flexible Spending Accounts: ☐ Yes ☐ No

	Per Pay Period	# of Pay Periods	Annual Election
Health Care FSA	$_____	X_____	= $_____
Dependent Care FSA	$_____	X_____	= $_____

(Day care expenses incurred during employment hours)

Effective date of coverage: **01/01/2018** The first payroll deduction will be on: ___/____/2018

My pay schedule is: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year, unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description.

I understand that I must submit a claim and appropriate documentation (e.g., explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Employee Signature		**Date:**	

Please scan and email this Completed form to Benefits@abelhr.com or fax to Abel HR at (609) 860-0440.