APPLICATION FOR FLEXIBLE SPENDING ACCOUNT

Employer				Group Number	Location

Employee's Last Name	First	Middle	Sex	Birth Date	Social Security Number

Employee's Mailing Address	City	State	Zip	Telephone

Hire Date	Effective Date	First Deduction Date

Marital Status

☐ Single ☐ Married

☐ Divorced ☐ Widowed

Are you or any member of your family covered by a Medical Insurance Plan ☐ YES ☐ NO If yes, please list the insurance company's name:

I elect to participate in the following Flexible Spending Account Options

☐ Un-reimbursed Medical Expenses

Annual Pledge $____________________

Per Pay Deduction $________________

☐ Dependent Care Expenses

Annual Pledge$____________________

Per pay Deduction $________________

☐ Dependent Coverage

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child/Children
- ☐ Employee & Family

☐ I decline participation in a Flexible Spending Account

DEPENDENT INFORMATION

FOR DEPENDENT COVERAGE, please list spouse/children below. If dependent benefits are declined, please complete the WAIVER below. If more space is needed, please attach another sheet.

Last Name	First Name	Birth Date	Sex	Social Security #	Relationship

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 the current plan provisions and tax laws. 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.

X____

Employee's Signature Date

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