Health/Dependent Care Flexible Spending Account Enrollment Form

This form is designed to be completed by using your computer and tabbing through the designated fields. If completing a printed copy by hand, please use black or blue ink, print clearly and only in the spaces provided.

Social Security Number 449-79-6981

Prior to completing this form, contact your benefit services group to determine your employer's preferred enrollment method.

First Name	M.I.	Last Name
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City	State
Seattle	WA

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Need help deciding how much to elect or how much you will save using a Flexible Spending Account?
VISIT OUR WEBSITE at www.spendingaccounts.info

I have reviewed the terms of my employer's Plan and I understand that I may elect coverage under either or both of the accounts below, subject to the terms of the Plan, for the Plan Year _____ .

	CONTRIBUTION PER PAY PERIOD	NUMBER OF PAY PERIODS REMAINING IN THE PLAN YEAR	YOUR ANNUAL ELECTION AMOUNT
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	$ 100.00	x 24	= 2,400.00
			CANNOT EXCEED $5,000 PER HOUSEHOLD PER YEAR*
HEALTH CARE FLEXIBLE SPENDING ACCOUNT	$ 100.00	x 24	= 2,400.00
			CANNOT EXCEED $2,550 PER PERSON PER YEAR*

** Your employer's maximum contribution may be less than the statutory limit. Please verify your employer's Plan limit prior to enrolling in the Plan.*

Please select your enrollment option below, sign and date your form and submit to your benefit services department:

☒ I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's Plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year noted above will be forfeited unless your Plan offers certain exceptions (e.g., grace period or carryover).

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

☐ I decline enrollment in my employer's Flexible Spending Account Plan.

Employee Signature _____ Date _____

Employer Section: ADP Control # _____ Employee ADP Company Code _____ Effective Date of Employee Election _____