



First Benefit Administrators

# FSA DEPENDENT CARE ENROLLMENT FORM

PLAN YEAR \_\_\_\_\_ THROUGH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

LAST NAME _____	FIRST NAME _____	MI _____	SOCIAL SECURITY NUMBER _____
DAYTIME PHONE ( ) _____		<input type="checkbox"/> CHECK BOX IF ADDRESS HAS CHANGED	
ADDRESS _____		CITY _____	
STATE _____	ZIP CODE _____	E-MAIL _____	

DEPENDENT CARE SPENDING ACCOUNT  YES, I ELECT TO PARTICIPATE

I AM PAID - WEEKLY \_\_\_\_\_ BI-WEEKLY \_\_\_\_\_ MONTHLY \_\_\_\_\_ SEMI-MONTHLY \_\_\_\_\_ AND ON

THAT BASIS CHOOSE TO REDIRECT A PRE-TAX DEDUCTION PER PAY PERIOD AS INDICATED ABOVE IN THE AMOUNT OF:

\$ \_\_\_\_\_

THE FIRST PAYROLL DEDUCTION DATE IS: \_\_\_\_\_

**MAXIMUM ANNUAL AMOUNT ALLOWED IS \$ 5,000.00** (or \$2,500.00 for a married individual filing a separate return)

AS AN ELIGIBLE EMPLOYEE, I UNDERSTAND A COPY OF THE SUMMARY PLAN DESCRIPTION (SPD) IS AVAILABLE AT MY PLACE OF EMPLOYMENT AND UNDERSTAND THE BENEFITS, RIGHTS AND OBLIGATIONS INCLUDED IN THIS PLAN. I UNDERSTAND THAT ELIGIBLE EXPENSES FOR ME, MY SPOUSE AND DEPENDENT, AS OUTLINED IN THE SPD AND IRS PUBLICATION 502, AND WHICH ARE NOT REIMBURSED UNDER ANY OTHER MEDICAL PLAN AVAILABLE TO ME, QUALIFY FOR REIMBURSEMENT UNDER THIS PLAN. I AGREE TO CONTACT THE PLAN ADMINISTRATOR/EMPLOYER FOR CLARIFICATION IF I HAVE ANY REASON TO BELIEVE THAT I HAVE RECEIVED A BENEFIT FOR ANY EXPENSES WHICH DO NOT QUALIFY. I UNDERSTAND THIS REDIRECTION MAY HAVE MINIMAL EFFECT ON MY SOCIAL SECURITY BENEFITS. I UNDERSTAND THAT AMOUNTS REDIRECTED INTO THIS ACCOUNT MAY NOT BE USED IN ANY OTHER BENEFIT PLAN, REFUNDED OR CARRIED OVER TO THE FOLLOWING YEAR. I UNDERSTAND THAT, EXCEPT FOR CERTAIN FAMILY SITUATIONS AS DEFINED BY THE SPD, MY PARTICIPATION IN THIS PLAN IS FOR THE ENTIRE PLAN YEAR. PRIOR TO THE BEGINNING OF EACH PLAN YEAR, I WILL BE GIVEN AN OPPORTUNITY TO CHANGE THE AMOUNT OF MY ELECTION OR REVOKE MY PARTICIPATION IF I DO NOT SUBMIT A NEW ELECTION, THE PRIOR YEAR'S ELECTION WILL REMAIN IN EFFECT FOR THE NEW PLAN YEAR. I UNDERSTAND THAT IN THE EVENT OF MY DEATH, ANY BENEFIT DUE ME WILL BE PAID TO MY ESTATE.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

A COPY OF THIS COMPLETED FORM SHOULD BE RETAINED FOR YOUR FILES AND THE ORIGINAL RETURNED TO YOUR HUMAN RESOURCES OFFICE OR YOUR BENEFITS ADMINISTRATOR

THEN MAIL OR FAX COMPLETED SIGNED FORM TO: **FIRST BENEFIT ADMINISTRATORS, INC**

13080 Belcher Road South, Suite A  
 Phone: 727.530.4144 ♦ Fax: 727.535.3977  
[www.firstbenefitadmin.com](http://www.firstbenefitadmin.com)