FIRST BENEFIT ADMINISTRATORS

FSA Dependent Care Enrollment Form

Plan Year:	_____ Through _____	
Employer Name		
Employer Phone		
Employer Address: *Street, City, State & Zip:*		
Employee Name (First & Last Name)		
Social Security Number		Date of Birth:
Daytime Phone Number ☐ *check if phone number has changed*		
Address: ☐ *check if address has changed*	Street: City: State: Zip:	
Email		

☐ **I ELECT TO PARTICIPATE IN THE HEALTH CARE SPENDING ACCOUNT**

I AM PAID: WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ SEMI-MONTHLY ☐

THE FIRST PAYROLL DEDUCTION DATE IS: _____

I CHOOSE TO REDIRECT A PRE-TAX *PER PAY PERIOD* AS INDICATED ABOVE IN THE AMOUNT OF:

$

Maximum Annual Amount is $5,000 (or $2,500 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 MYSELF, 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 BENEFITS ADMINISTRATOR

PLEASE MAIL OR FAX THE COMPLETED SIGNED FORM TO: FIRST BENEFIT ADMINISTRATORS, INC
9455 Koger Blvd N. Suite 100, St. Petersburg, FL 33702 Phone: 727.530.4144 ◊ Fax: 727-532-9602
www.firstbenefitadmin.com