



Flexible Spending Account Enrollment and Election Change Form

Health Care and Dependent Care Accounts

Please complete this enrollment form and return it to your HR/Benefit Department. Incomplete forms will be returned to you.

I. Employee Information

Employer Name					
Your Name (Last, First, Middle)		Social Security Number	Date of Birth	Gender	Marital Status
Mailing Address		City	State	Zip	Primary Phone Number
Email Address					

II. Enrollment Elections

Check the plan(s) you want to enroll in and fill in the election amount you want withheld from your pay.

Yes. I elect to participate in a FSA Health Care Account. Annual Election: \$ _____

No. I do not elect to participate in a FSA Health Care Account.

Yes. I elect to participate in a FSA Dependent Care Account. Annual Election: \$ _____

No. I do not elect to participate in a FSA Dependent Care Account.

III. Debit Card

Would you like to request an additional debit card for your spouse?

Yes No If yes, please provide the following information.

Spouse's Name (Last, First, Middle)		Spouse's Social Security Number		
Spouse's Mailing Address (If Different From Participant)		City	State	Zip

IV. Certification

My employer and I agree that my taxable income will be reduced (pre-tax) each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status, as defined under IRS code. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that any amount remaining in my Health Care and/or Dependent Care Accounts at year end will be forfeited, in accordance with current plan provisions and the IRS code.

Employee Signature

Date

EMPLOYER USE ONLY		Date of Hire	Employee Alternate ID (If Applicable)	# of Pay Periods Remaining	
Payroll Cycle: Weekly Bi-Weekly Semi-Monthly Other _____				Pay Date of First Election	
Health Care Deduction Per Pay Period: \$		Effective Date	Dependent Care Deduction Per Pay Period: \$		Effective Date
Transaction Type: Initial Enrollment New Plan Year Mid-Year Change Termination				Medical Plan Code: (Please refer to your implementation documents.)	

I have reviewed the above information and approve of the employee's participation in the Flexible Spending Account program.

Employer Signature

Date

Note to Employer: Please retain a copy of this form for your records. Submit completed forms to your account representative via: 1.) a password protected email attachment or 2.) fax: 401-457-7266 or 3.) mail: Altus Benefit Administrators, PO Box 1643, Providence, RI 02901-1643.