BENECON

Flexible Spending Account Enrollment Form

Enrollment Effective Date:___ Plan Year:

EMPLOYER/EMPLOYEE INFORMATION

Company:	Date of Hire:		
Employee First Name:	Mi:	Employee Last Name:	
Social Security Number:	Address Line 1:		
Address Line 2:	City:	State:	Zip:
Phone Number:	Email Address:		
Birth Date:	Gender:		

Payroll Frequency: ☐ Weekly (52) ☐ Biweekly (26) ☐ Biweekly (24) ☐ Monthly ☐ Other Paycheck

Deductions Start on:

Number of Deductions in the Plan Year:

DEPENDENTS TO BE COVERED

First Name	MI	Last Name (If Different)	SS# (Required)	Date of Birth	M/F	Relationship

ACCOUNT ELECTIONS

Health Care Flexible Spending Account

☐ elect $___ per payroll or $___ for the plan year to be contributed on a pre-tax basis to my Health Care Flexible Spending Account. I understand this amount will be deductible from my pay throughout the Plan Year.

☐ do not wish to participate in the Health Care Flexible Spending Account.

Dependent Care Flexible Spending Account

☐ elect $___ per payroll or $___ for the plan year to be contributed on a pre-tax basis to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

☐ do not wish to participate in the Dependent Care Flexible Spending Account.

SIGNATURE

I have reviewed the above election(s) and understand my choices will remain in effect for the entire Plan Year unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan Year will be forfeited unless my employer allows up to $640 dollars to roll in the next Plan Year. I certify (1) the Benefits Debit Card will only be used to pay for the eligible medical expenses of myself, my spouse, and my dependents; (2) the Benefits Debit Card will not be used for expenses that have already been reimbursed; (3) I will not seek reimbursement under any other health plan for expenses paid for with the Benefits Debit Card; and (4) I will acquire and keep sufficient documentation for expenses paid with the Benefits Debit Card.

_____ _____

Signature Date