

# EMPLOYEE SPENDING ACCOUNT ENROLLMENT FORM



EMPLOYER NAME: <u>County of Imperial</u>	GROUP NUMBER: <u>To be determined</u>
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EMPLOYEE NAME LAST	FIRST	MI	<input type="checkbox"/> M <input type="checkbox"/> F SEX	ID #	SS#:
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EMPLOYEE ADDRESS: <input type="checkbox"/> Please check if this is a change in address			DATE OF BIRTH: ____/____/____
Street			DATE OF HIRE: ____/____/____
City	State	Zip	
Email Address	Fax Number (for return correspondence)		
Home Phone	Work Phone		

**PLEASE COMPLETE**

I ELECT THE FOLLOWING:	Amount Per Pay Period	Annual Election	
		Actual	Maximum
Healthcare Account: <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____	\$ 5,000 Plan Year
Dependent Care Account: <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____	\$ 5,000 Calendar Year

Pre-Tax Premium Deductions: health insurance premiums, and all other eligible insurance premiums, will be excluded from taxable income. The employer will automatically apply pre-taxation of these insurance premiums unless you specifically decline the option. If you do not wish to have your insurance premiums pre-taxed, you must notify Human Resources during open enrollment.

**QUALIFIED DEPENDENTS**  
Following are the IRS qualified dependents whose claims I may request reimbursement for throughout the Plan Year.

LAST NAME	FIRST NAME	RELATIONSHIP TO EMPLOYEE

**AUTHORIZATION**

By signing this form, I certify the following:  
 1) I have read the information provided to me on Flexible Benefits. 2) The above information is correct and I authorize the salary reductions as I have indicated. 3) I understand that any amounts remaining in my Health and/or Dependent Care Account(s) – not used for eligible expenses incurred during the Plan Year, including the grace period, may not be carried forward, according to Plan provisions and pre-tax laws. 4) I understand that the elected salary reduction(s) will remain in effect for the Plan Year and can only be changed if I experience a change in my status (e.g. birth, adoption, marriage, divorce, loss or gain of spouse's employment), according to the Summary Plan Document.

EMPLOYEE SIGNATURE (Required)	DATE
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INFORMATION SUPPLIED BY EMPLOYER: Effective date: _____					
Frequency of Pay:	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Other
First Pay Date of Deductions:	____/____/____	Division/Location:			