

# CORE Benefits, Inc.

## FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM PAYROLL DEDUCTION AUTHORIZATION

Employer Name: \_\_\_\_\_ Plan Number: \_\_\_\_\_

Please check one:  New Enrollment  Family Status Change  Effective Date  
 Waiver of Election  Cancel/Term Date \_\_\_\_\_

### Employee Information

Full Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### Election Information

#### Health Care Account

- I would like to enroll in the Health Care Spending Account  I do not wish to enroll in the Health Care Account  
 I wish to deposit the following amount on a pre-tax basis to the Health Care Spending Account

<u>Deduction per pay period</u>		<u>Number of deductions</u>		<u>Annual Election</u>
\$ _____	x	_____	=	\$ _____

#### Dependent Care Account

- I would like to enroll in the Dep Care Spending Account  I do not wish to enroll in the Dep Care Account  
 I wish to deposit the following amount on a pre-tax basis to the Dependent Care Spending Account

<u>Deduction per pay period</u>		<u>Number of deductions</u>		<u>Annual Election</u>
\$ _____	x	_____	=	\$ _____

### Waiver of Election

I do not wish to enroll in either the Health Care Spending Account or the Dependent Care Spending Account; however, I authorize my employer to withhold the required contributions for my Group Health Premiums. These required contributions will be pre-tax contributions and I understand that I cannot change or revoke my contributions before the next anniversary date of the plan unless I have a qualified family status change.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that my annual contributions can only be used to reimburse expenses under each account and that I will forfeit any funds remaining in my account at the end of the plan year. I understand that I cannot change or revoke my contributions before the next anniversary date of the plan unless I have a qualified family status change. My signature certifies that I authorize pre-tax payroll deductions as contributions to my health and/or dependent care accounts as indicated above and for the required contributions for my Group Health Premiums.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_