

Flexible Spending Account (FSA) & Dependent Care Account (DCA) Enrollment Form

* Effective Date: _____ Special Notes: _____

*** REQUIRED FIELDS ***

| | | | |
|--------------------------|-----|----------------------|--------------------|
| *Company Name: | | | |
| *Employee First Name: | *MI | *Employee Last Name: | |
| *Social Security Number: | | *Address Line 1: | |
| Address Line 2: | | *City: | *State: *Zip: |
| *Phone Number: | | Cell Phone Number: | |
| *Birth Date: | | *Gender: | |

DEPENDENTS TO BE COVERED

| *First Name | MI | Last Name (If Different) | *S.S. # (Required) | *Date of Birth | *M/F | *Relationship |
|-------------|----|--------------------------|-----------------------|----------------|------|---------------|
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PLAN YEAR ELECTION

I authorize my employer to deduct a pre-tax contribution from my compensation for the following benefits:

The 2019 maximum pre-tax employee contribution for Flexible Spending Accounts is \$2,700 per year.

***Please indicate the total amount you will be contributing for the entire plan year:**

Flexible Spending Account *Annual Election \$ _____

The 2019 maximum pre-tax employee contribution for Dependent Care Accounts is \$5,000 per year if single or married, filing a joint tax return, or \$2,500 if married filing separately.

***Please indicate the total amount you will be contributing for the entire plan year:**

Dependent Care Account *Annual Election \$ _____

AUTHORIZATION OR WAIVER OF PARTICIPATION

* I request to participate in the benefits indicated above. I understand that my elections indicated are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan.

Under penalty of perjury, I agree to use the debit card solely for the purchase of eligible expenses. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account. I understand that these expenses cannot be claimed on my income tax return. By signing this form I hereby authorize my employer to deduct any ineligible expenses paid for with the *Choice Strategies Card*TM from my paycheck. I understand that any unauthorized use may result in the loss of my *Choice Strategies Card*TM.

I elect to participate in the *Choice Strategies* FSA/DCA plan I do not elect to participate in the *Choice Strategies* FSA/DCA plan

By signing below I hereby authorize the release of claim information to my employer, their broker, and *Choice Strategies*:

* Employee Signature: _____ Date: _____