Sheakley
It's done.

ENROLLMENT FORM

SECTION 1: Participant Data

Please legibly complete the following information to set up your account.

Employee Name (First/Last)			Social Security #	
Jane Doe			555-55-5555	
Home Address		City	State	Zip Code
1234 Sheakley Circle		Sheakley	CA	12345
Hire Date	Birth Date	Email Address		
01/01/2000	01/01/1980			
Employer: City of Torrance				

SECTION 2: Elections

Enter the amount you wish to contribute per pay period, the number of paychecks you will receive during the entire plan year, multiply the per pay by the number of paychecks for the annual election, and enter the first paycheck date in which a deduction will be withheld.

Plan Year: 1/1/2014-12/31/2014	Per Pay Contribution	# of Paychecks Remaining	Annual Election	Effective Paycheck Date
Health Care Reimbursement (Annual Limit $ 2,500.00)	$ 0.00	# 0	$ 0.00	01/03/2014
Dependent Care Reimbursement (Annual Limit $5,000.00 per household or $2,500.00 if married filing separate)	$ 0.00	# 0	$ 0.00	01/03/2014

SECTION 3: Pre-Taxed Premiums

I understand my insurance premiums, offered by my employer only, will be deducted on a pre-tax basis unless I note otherwise, in writing, to my Human Resources Office.

SECTION 4: Plan Information

Please read the following information regarding this enrollment. If you do not wish to participate in the Flexible Benefit Accounts, sign the declination line. If you wish to enroll into the Flexible Benefit Plan, sign the participation line.

I wish to participate and deposit to the Flexible Spending Account (FSA) as shown above. I understand that my election may not be terminated or changed unless I have a qualified life event as outlined by the IRS. I understand that all claims must be for services provided (not paid) during my coverage period. I further understand that the IRS requires a forfeiture of any remaining balance in my account, as of the last day of the grace period in which I am allowed to submit claims. I understand that upon termination of my coverage (due to a qualified life event or termination of employment) I cannot continue to incur additional expenses; I may only submit claims for services performed prior to my termination date. Upon termination of my Healthcare Reimbursement Account, I may be able to elect COBRA to continue my coverage. In order to receive reimbursement from this account, I must complete and sign a claim form and attach all necessary documentation for myself or my dependents. I understand the plan provisions have been outlined in the Summary Plan Description available to me from my employer.

In addition, I understand that if I have a Health Savings Account (HSA), it is my responsibility to review the FSA plan information to make sure that I am able to participate in both the HSA and the FSA. If my plan allows for participation in both a FSA and a HSA plan, I understand that I can only submit dental and vision expenses toward my FSA account.

PARTICIPATION SIGNATURE: Jane Doe **DATE:** 11/4/13

WAIVER: **At this time I wish to waive participation in the Flexible Benefit Account.**

DECLINATION SIGNATURE: _____ **DATE:** _____

All Enrollment forms must be submitted to your HR Department for processing.

EMPLOYER SIGNATURE: _____ **DATE:** _____