American Benefit Services
Flexible Benefit Plan Enrollment Form

Last Name	First Name	SSN
Address		
City	State	Zip

Date of Birth	Date of Hire	Email

Please list all Dependents to be covered under your plan:

Spouse: Date Of Birth:	Child: Date of Birth:
Child: Date of Birth:	Child: Date of Birth:

I understand that by participating in this plan:
My Social Security benefits may be slightly reduced as a result of my elections; My annual withholding (W-2) form will reflect my reduced taxable income; I cannot change this election during the plan year unless there has been a significant increase in cost, or a family status change as outlined in my Summary Plan Description; My employer may cancel this election, if necessary, to comply with the provisions of the Internal Revenue Code; My portion of the cost of the Benefit Plans paid with pre-tax dollars will automatically increase or decrease, as the case may be, to reflect the change in the cost of the benefits.

Please make a benefits selection (Check one, both or neither of the boxes below. Failure to check a box will be viewed as a waiver of that particular benefit)

Medical Reimbursement $____________ ÷ __________ = $______________
(Maximum Election cannot exceed $????) Plan Year Election # Paychecks Amount per check

Dependent Care Plan $____________ ÷ __________ = $______________
(Maximum Election cannot exceed $5000) Plan Year Election # Paychecks Amount per check

Reimbursement Options:

Direct Deposit – Please complete the attached Direct Deposit form, and include a copy of a voided check from the account which the funds will be deposited. I authorize American Benefit Services to access my designated account for the purposes of depositing my FSA reimbursements, and to retrieve any reimbursement that may have been made in error.

Check

Waiver of Pre-Tax Benefits: (Do not check this box if you have elected to participate in either the Medical Flex or DCAP Plan)

I elect to waive participation in both the Medical Flex and DCAP pre-tax benefits under the Flexible Spending Account. I understand that I cannot change this election during the plan year unless there has been a family status change as outlined in my Summary Plan Description.

______________________________ ____________________
Employee Signature Date