

# 2005 FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

**COMPANY:** \_\_\_\_\_

**Election Form/ Salary Reduction Agreement, PLAN YEAR / 05— / 05**

**Submittal Deadline:** \_\_\_\_\_

Employee # \_\_\_\_\_ Name \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Please Print Clearly

Address \_\_\_\_\_  
Street City State Zip Code

**INDICATE ANNUAL AMOUNT**

1. Health Care Reimbursement Account 1. \$ \_\_\_\_\_  
(\*Enter the total amount that you wish to deposit for the  
period January 1, 2005 through December 31, 2005).  
Minimum \$100. Maximum \$
2. Dependent Care Reimbursement Account 2. \$ \_\_\_\_\_  
(\*Enter the total amount that you wish to deposit for the  
period January 1, 2005 through December 31, 2005)  
Minimum \$100. Maximum \$5,000.

**\*MID-YEAR ENROLLEES DEDUCTIONS BEGIN AS OF THE FIRST PRACTICAL PAY PERIOD AFTER ENROLLMENT FORM IS RECEIVED IN PAYROLL.**

**I understand that:**

- ◆ Deductions will be made in equal installments on a pre-tax basis during the coverage period.
- ◆ I may not change or discontinue my election unless I have a qualifying event either in my employment or my family status. If a qualifying event occurs, I have 31 days from the date of the event to make a change to my election.
- ◆ I may claim reimbursement for eligible expenses incurred during the coverage period in which I was a participant in the Flexible Spending Accounts. Any deposits not used for services incurred between January 1, 2005 and December 31, 2005, or during the period in which I was enrolled, will be forfeited. Claims must be submitted by March 31, 2006.

Signature \_\_\_\_\_ Date \_\_\_\_\_