FLEXDOLLARS™ ENROLLMENT FORM

Plan year ____/____/____ to ____/____/____

Company Name:_____

Participant Name:_____ Social Security Number:_____-_____-_____

Address:_____ Pay Periods: ☐ Weekly (52)
☐ Bi-Weekly (26)
☐ Semi-Monthly(24)
☐ Monthly (12)

_____

Please check all types of coverage you have either through your employer or spouse:

☐ Health ☐ Dental ☐ Vision

☐ Open Enrollment New Hire (Hire date:____/____/____)

☐ Change in Status Explanation:_____

HEALTH CARE SPENDING ACCOUNT

I elect to participate. ☐ Yes ☐ No

I authorize the amount below to be deducted from each of my paychecks:

$_____ x _____ = $_____
(per pay period) (insert number of pay periods) Total annual election

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

I elect to participate. ☐ Yes ☐ No

I authorize the amount below to be deducted from each of my paychecks:

$_____ X _____ = $_____ (Not to exceed $5000)
(per pay period) (insert number of pay periods) Total annual election

I authorize my employer to reduce my earnings for the plan year indicated above. Funds deposited into my Health Care and/or Dependent Care Flexible Spending Account(s) will be available to pay for eligible expenses during the plan year. I understand that I can change my contributions during the plan year only if I experience a "family status change". I will have sixty (60) days after the plan year ends to submit reimbursement requests for expenses incurred during the plan year. I understand that Internal Revenue Service rules require that I forfeit unused account balances.

Employee Signature:_____ Date_____

Flex Checks

2030 Leonard NW
PO Box 141215
Grand Rapids, MI 49514-1215

(616) 791-7900
Fax: (616) 791-7901