Flexible Spending Account Enrollment Form

EMPLOYER NAME:_____ PLAN YEAR: _____

EMPLOYEE NAME:_____ MEMBER ID OR SSN: _____

GENDER: FEMALE MALE DOB: _____ HIRE DATE: _____ MARITAL STATUS: SINGLE MARRIED

ADDRESS: _____ CITY: _____ STATE:_____ ZIP: ____ _____

EMAIL: _____ PHONE: _____

First Payroll Deduction Date: _____

Paycheck Frequency: Weekly Bi-Weekly Monthly Semi-monthly

Flexible Spending Account Reimbursement Plan Year Annual Election $ _____

(Maximum per plan year is **$2,700**) (Minimum per plan year is $0.00)

Dependent Care Reimbursement Plan Year Annual Election: **$5,000**) **$**_____

(Maximum contribution to the Dependent Care FSA is **$5,000** (or **$2,500** if married and filing separately).

List name(s) of dependents:

_____ _____

_____ _____

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deductible amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Spending Amount will be in effect for the entire plan year and cannot be revoked except as permitted by federal law. I understand that my share of eligible group premium(s) automatically will be deducted before taxes. I understand this is for the current plan year only, and I must renew this authorization each new plan year.

Employee Signature:_____ **Date:** _____

DECLINE PARTICIPATION: I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant under these plans.

Employee Signature: _____ **Date:** _____

Please send completed and signed form to:

Mail: **ARC Administrators**
PO Box 12290
Lexington, KY 40582
Email: **FSA@arcsvs.com**
Fax: **(859) 243-0381**
Toll Free Phone: (877) 309-2955