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Flexible Spending Account Enrollment Form

SECTION A EMPLOYER/EMPLOYEE INFORMATION

Employer Name	Group Number	Employer Location (if applicable)	Effective Date

Employee Name	Employee SSN	Date of Birth	
Address	**City**	**State**	**Zip**
Employee Email Address	**Daytime Phone**	**Employee Gender**	
		Female	Male

SECTION B Election(s)

Use the table below to select your Flex benefits.

	Annual/Mid Year Election Pledge	Divided By	# of Pay Periods: Annually / Mid Year	Equals	Deduction from each pay period
I elect to participate in the Health Flexible Spending Account		/		=	$
I elect to participate in the Dependent Care Account		/		=	$
(Plan Year Example)	$3,200.00	/	24	=	Example $133.33

SECTION C Allied Flex Debit Card SSN and DOB are quired. Dependent must be over 17.

Please complete the information below for all dependents who should have an Allied Flex Debit Card.

Name	Date of Birth	SSN	
Spouse Name:	Date of Birth:	SSN:	Keep current dependent card active Request new dependent debit card
Dependent Name:	Date of Birth:	SSN:	Keep current dependent card active Request new dependent debit card
Dependent Name:	Date of Birth:	SSN:	Keep current dependent card active Request new dependent debit card
Dependent Name:	Date of Birth:	SSN:	Keep current dependent card active Request new dependent debit card

SECTION D Direct Deposit

I would like to participate in Direct Deposit:

YES NO

If yes, please complete the attached "Flex Direct Deposit Enrollment Form" and include a voided check.

I am currently participating in direct deposit. Please keep current banking information on file.

SECTION E EMPLOYEE CERTIFICATION

I certify the above information is true and correct, and I authorize any premiums and Flexible Spending Account contributions, if applicable, to be paid on a pre-tax basis pursuant to Internal Revenue Code Section 125. I understand that any amounts which are not used for eligible expenses incurred during the Plan Year or Grace Period, will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the salary reduction(s) will be in effect for the Plan Year and cannot be revoked except as authorized by current Plan provisions and laws.

Employee Signature **Date**

IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline participation.

Employee Signature **Date**

Employer Use Only (Required for processing)

Employee's Flex Plan Effective Date	First Payroll Date	Payroll Cycle	I agree this form is correctly filled out by the Employee.
			HR Signature: