

# FLEXIBLE SPENDING ACCOUNTS

## 2009 ENROLLMENT APPLICATION AND DEDUCTION AUTHORIZATION

(Please Print Clearly)

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
(last) (first)

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Company Name \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Home Phone Number \_\_\_\_\_

### **Please Indicate Your Elections Below:**

#### HEALTH CARE REIMBURSEMENT ACCOUNT

I authorize a 2009 plan year contribution of \$\_\_\_\_\_ to be made to my Health Care Reimbursement Account. This amount will be deducted from my pay on a pre-tax basis in equal amounts throughout the course of the plan year.

#### DEPENDENT CARE REIMBURSEMENT ACCOUNT

I authorize a 2009 plan year contribution of \$\_\_\_\_\_ to be made to my Dependent Care Reimbursement Account. This amount will be deducted from my pay on a pre-tax basis in equal amounts throughout the course of the plan year.

#### DECLINE

I decline this benefit.

### **I understand by my participation in these accounts that . . .**

1. I may not change or stop my contributions during the plan year unless my family or employment status changes, (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, unpaid leave of absence, etc.). Such a change in my election must be the result of, and consistent with, the event causing the election change, and must qualify under the terms and conditions of the plan.
2. IRS rules require that any amount not used for covered expenses under my Health Care Reimbursement Account and Dependent Care Reimbursement Account cannot be returned to me. I understand that I have until the end of the designated run out period each year to submit claims incurred during the prior plan year.
3. I have received and read all written materials provided to me describing the plans, and agree to the terms of participation set forth in the written materials.

### COMPLETE, SIGN, AND DATE THIS FORM

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

#### HR USE ONLY

Aetna effective date: \_\_\_\_\_ HCSA deduction amount: \$ \_\_\_\_\_ DCSA deduction amount: \$ \_\_\_\_\_  
(mm/dd/yyyy)

Payroll effective date: \_\_\_\_\_  
(mm/dd/yyyy)

Biweekly  Monthly