Dependent Care Only Election Form

Employer Name: _____ Employer Group #: _____

Employee Name: _____ SS#: _____

Home Address: _____ Date of Birth: _____/_____/_____

City: _____ State: _____ Zip: _____ Date of Hire: _____/_____/_____

Marital Status: ◯ Single ◯ Married Gender: ◯ Male ◯ Female

Effective Date: _____/_____/_____

LIST # OF PAY CYCLES: _____

Dependent Care FSA

You may choose to contribute pre-tax dollars that can be used to pay certain dependent care expenses incurred during the plan year You should only contribute an amount that you will be certain to use for dependent care because current tax law does not allow you to receive a refund or to use the balance for another purpose.

☐ I elect not to participate at this time. I realize that should I desire to enroll in this plan in the future, I must wait until the next annual enrollment.

☐ I elect to reduce my salary to fund my dependent care spending account with pre-tax dollars. $_____ and $ _____
PER PAY ANNUAL

Employer Contribution: $ _____
ANNUAL

I have read this election form and accompanying materials regarding the options available to me under the Pre-tax Benefits Plan. I understand that this election is binding and may not be changed except at annual enrollment or if I experience a change in status such as reduction in hours, marriage, divorce, birth or adoption of a child, or death of a dependent.I authorize my employer to reduce my salary by the amount indicated above.

Employee's Signature: _____ Date: _____

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