FLEXFACTS
a company of grant benefit solutions

Please return this form to your human resources representative.

Flexible Spending Account Enrollment Form

Personal Information

Employer: _____

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Alternate Phone: ( ) _____

E-mail Address: _____

Social Security Number: _____

Birth Date: _____ Effective Date: _____

Signature: _____

Date: _____ Plan Year Start: _____

Benefit Election

Date of First Deduction: _____ Number of Remaining Pays _____

Medical FSA Annual Election: _____ Per Pay: _____

Dependent Care Annual Election: _____ Per Pay: _____

Parking Monthly Contribution: _____ Per Pay: _____

Transit Monthly Contribution: _____ Per Pay: _____

Spouse or Dependent Card Information

Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Soc. Sec. Number: _____

Relationship: _____

- By signing this form I agree that my cash compensation will be redirected by the amounts set forth above.
- If you do not return this form to your employer by your effective date you will not be able to participate in the plan until the following plan year.
- You must sign a new election form each year at open enrollment, your accounts will not automatically renew.
- You cannot change this election during the plan year unless you have an eligible change in status.
- This agreement is subject to the terms of the company's Flexible Benefits Plan.