

Accrue CMS

EMPLOYEE ENROLLMENT FORM

Company Name:		Name:			
Address:		City:	State:	Zip Code:	Hire Date:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number:		Email Address:	
Social Security Number:					

Note: **Election changes are only allowed with a qualifying change of status event. Changes requests must be submitted within 30 days of the event.**

Pay Period: (Check the box which indicates the frequency of your paychecks)

WEEKLY BI-WEEKLY SEMI-MONTHLY MONTHLY OTHER

FSA Health Care Annual Election \$ _____ (\$3,400 annual maximum)	FSA Dependent Care Annual Election* \$ _____ (\$7,500 maximum family, \$3,750 maximum per spouse if married filing separately)
---	---

I decline to participate

I hereby authorize my election(s) for the benefit(s) designated above for the plan year. I understand that my pay will be reduced by the elected amounts. I understand that these elections are annual elections and cannot be changed except in the case of a qualifying event. I understand that any unused balance in any benefits at the end of the plan year or upon my termination of employment is subject to forfeiture.

Employee Signature: _____ Date: _____

*Dependent Care is for daycare(baby-sitting) of children or elderly dependents. It is not for medical expenses for your dependents