2011 FSA Election Form & DCAP Election Form

20815 N Cave Creek Rd
Phoenix, AZ 85024

P. (623) 580-4900
F. (623) 580-4902

Part 1- Employer Information

Employer Name:	Date of Hire:

Part 2- Personal Information - Primary Account Holder

First Name:	MI:	Last Name:	Date of Birth:
Social Security No:	Driver's License #:		State Issued:
Home Address (NO PO Boxes):			
City:	State:	Zip Code:	
Work Phone:	Home Phone:	Cell Phone:	Email Address:

Part 3- Additional Authorized Cardholders

Name:	DOB:	Social Security #:	Relationship:
Shipping Address (If different from above):			

Name:	DOB:	Social Security #:	Relationship:
Shipping Address (If different from above):			

Name:	DOB:	Social Security #:	Relationship:
Shipping Address (If different from above):			

Part 4- Flexible Spending Account (FSA) Contribution Election

☐ **I choose to participate in the Health Care Flexible Spending Account**

I elect a Per Pay Period Withholding of ____________

Total Annual Contribution ____________ *(not to exceed $5,000)*

☐ **I choose NOT to participate in the Health Care Flexible Spending Account**

Part 4- Dependent Care Assistance Plan (DCAP) Contribution Election

☐ **I choose to participate in the Dependent Care Assistance Plan**

I elect a Per Pay Period Withholding of ____________

Total Annual Contribution ____________

(not to exceed $5,000 or $2,500 if married filing separately)

☐ **I choose NOT to participate in the Dependent Care Assistance Plan**

Part 5- Required Signature *(Important- Please Read Before Signing)*

1. I understand that according to IRS regulations, that my election amount for the year cannot be changed except under qualifying change in family status (marriage, divorce, death of spouse or child, birth or adoption of child, change of employment),
2. I understand that by waiving my right to contribute at this time, I cannot change or begin contributing to this plan until next January 1, unless I have a qualified change in family status,
3. I understand that I can only be reimbursed for qualified expenses incurred during the plan year and that all money remaining in my account(s) at the end of the year will be forfeited,
4. I understand that my election will be withheld evenly from each paycheck during the Plan Year on a pre-tax basis
5. I understand that my Dependent Care election cannot exceed the annual salary of myself or my spouse (if married), nor $5,000

Signature	Date: