



Flexible Spending Account (FSA) Enrollment Form

Section A. Employee/Spouse Information

(Check one)
New Hire Hire Date: ___ / ___ / ___
Open Enrollment

Last Name:
First Name:
Middle Initial:

Social Security Number:
[] [] [] - [] [] - [] [] [] []

Date of Birth: ___ / ___ / ___
Gender:
Male Female

Address:
City:
State:
Zip:

Home Phone:
Work Phone:

Spouse or Dependent's Full Name for second POMCO Group take care Visa debit card (First, Last):

Section B. Contribution Amount

Table with 4 columns: Plan, Annual Contribution, Number of Pay Periods, Contribution Amount per Pay Period. Rows include Medical/Dental, Dependent Care, Parking, Transit, and Total Contribution.

Section C. Employee Signature and Authorization

I understand the following:
• My taxable income will be reduced each pay period during the plan year by an equal portion of the elected contribution amount.
• I may change my election in the event of certain changes in my status and, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year.
• That my signature below states that I have received, read and understand the Summary Plan Description.
• The take care Visa debit card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source.
• Any FSA funds not used within the plan year, or any applicable grace period, will be forfeited.
• If a payment is made that is not for qualified expenses I will repay my employer. If those expenses are not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee Signature: _____ Date: _____
Employer Signature: _____ Date: _____