CONEXIS
human resourceful®

Flexible Benefits Enrollment Form
Health Care and Dependent Care

Complete This Form And Return It To Your Human Resources Representative

Company Name: _____

Part 1 – Employee Data

Employee Name (Last, First MI.)

Social Security Number

Home Address (include apartment number)

City State Zip Code

Date of Birth Date of Hire Sex (M or F)

Part 2 – Elections

- Health Care Reimbursement Account

  ☐ I elect to participate $_____ per pay period x ____ remaining pay periods = $ _____Plan Year Total
  ☐ I elect to waive coverage

- Dependent Care Reimbursement Account

  Annual maximum allowable is:
  - $5,000 for married filing jointly or single
  - $2,500 if married filing separately

  ☐ I elect to participate $_____ per pay period x ____ remaining pay periods = $ _____ Plan Year Total
  ☐ I elect to waive coverage

Part 3 – Authorization

I have reviewed the terms of my employer's Flexible Benefits Plan. I understand that I may elect coverage under any or all of the above components. I understand that the premiums for the coverages that I elect will be deducted from my compensation on a pre-tax basis and the deductions cannot be changed until the next plan year unless there is a change in status. I have read and agree to the terms of participation.

_____ _____
Employee's Signature Date

For Employer Use Only					
Company Name	Division	Effective Date	Pay Cycle	Entered in Payroll	Initial