Health/Dependent Care Flexible Spending Account Enrollment Form

Employer: Lee County Commission Effective Date: January 1, 2016

Please complete the information in PRINT using blue or black ink Social Security Number - ☐☐☐

First Name M.I. Last Name Date of Birth

Mailing Address

City State Zip Code

E-mail Address Phone Number (xxx-xxx-xxxx)

Flexible Spending Account Type	Pay Period Deduction	Annual Election
Health Care Spending	$	$
Dependent Care Spending	$	$
Total Pre-Tax Dollars	$	$

☐ I ELECT to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualifying change of status per IRS regulations.

At the end of the current plan year, the plan provides a 2.5 month grace period. Any unused funds from the current plan year can be used for the first 75 days of the new plan year. Funds will be forfeited if not expensed during the 2.5 month grace period.

If the Plan Administrator determines that an expense I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan in order to reimburse the unqualified expense.

☐ I DECLINE enrollment in my employer's Flexible Spending Account Plan. I understand I may not enroll in this Plan until the next enrollment.

Employee Signature Date

Please list all eligible dependents:

Name	Relationship	Date of Birth	Social Security Number

PO Box 240518
Montgomery, AL 36124
Ph: 866.396.3967
Fax: 334.396.7767
www.allianceinsgroup.com
fsa@allianceinsgroup.com

Alliance Insurance Group
Employee Benefit Consultants