

CHC

ENROLLMENT FORM Flexible Spending Account

If you have questions or need assistance please
call (877) 819-9413, or email us at
chcbenefits@chc-inc.com.com

Instructions

1. Complete all sections, supplying all requested information. Sign and date the form.
2. Fax or mail Enrollment Forms to: **CHC @ FSAontheweb.com**
FSA Enrollment, P.O. Box 827, Lanham, MD 20703-0827
Fax: 301-306-2509

Employee Information

NAME (Last) (First) (M.I.)	SOCIAL SECURITY NUMBER
HOME ADDRESS- Please check here if this is a new address <input type="checkbox"/> (Street)	EMPLOYER
(City) (State) (Zip Code) EMAIL ADDRESS	WORK PHONE NUMBER ()

Spouse and Dependent Information (Please enclose information for additional dependents on a separate sheet of paper)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH			SOCIAL SECURITY NUMBER	RELATION TO EMPLOYEE (Spouse, Son, Daughter, Eligible Parent)
			Month	Day	Year		

Flexible Spending Account Election

	CHECK ALL THAT APPLY	AMOUNT OF SALARY DEDUCTION	PLAN YEAR DATES
<input type="checkbox"/>	Dependent Care Account	\$ _____ Per calendar year OR \$ _____ Per pay period _____ pay periods per year.	Start Date _____ End Date _____
<input type="checkbox"/>	Health Care Account	\$ _____ Per calendar year OR \$ _____ Per pay period _____ pay periods per year.	Start Date _____ End Date _____

Acknowledgement/Salary Reduction Agreement (Must be completed by all Employees)

I acknowledge my election as indicated above.
In choosing to participate in my company's Flexible Spending Account Program, I authorize the above stated amount(s) to be deducted on a pre-tax basis. I understand these deductions cannot be stopped or adjusted during the plan year unless I experience a change in status (which must be filed within 30 days of the change). I further understand that any unused amounts remaining in my spending accounts at the end of the plan year or date of my termination will be forfeited. However, I will have an additional grace period, as defined by my employer, the end of the Plan Year or date of my termination to submit receipts for reimbursement for services received during the Plan Year or employment period.

Employee Signature

Date

Dependent Care Qualification Statement (Must be completed by all Employees enrolling in the Dependent Care Account)

I certify that my provider, if a family member, is over the age of 19 and NOT my dependent.
I certify that my child/children are under the age of 13 during the plan year OR any child/children/dependent 13 years or older is my dependent who is not able to care for himself/herself because of a physical or mental disability and:

- I certify that I am a single parent and working full time.
- I certify that my spouse's annual income exceeds the amount I am claiming for Dependent Care.
- I certify that my spouse is enrolled full-time at an institute of higher learning.
- I certify that my spouse is medically disabled and cannot care for our dependents.

Employee Signature

Date