FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

______________________	______________________		
Employee Name	**Street Address or P.O. Box**		
Deseret Mutual Identification Number	**City**	**State**	**Zip Code**

As an employee of ____ , I choose to participate in the Flexible Spending Account Program administered by Deseret Mutual for the qualifying expenses indicated below:

❑ Medical / Dental Flexible Spending Account

Account is to be used for qualifying medical/dental expenses for diagnosis and treatment provided by a licensed practitioner of the healing arts. **This includes eligible medical/dental expenses for you and/or your dependents.**

Is your spouse eligible for other group health plan benefits? ❑ Yes ❑ No

Total Annual Reduction

$

(Annual maximum = **$6,000**)

❑ Dependent Care Flexible Spending Account (Day Care)

Account is to be used for qualifying dependent care expenses for a person who qualifies as a legal dependent on your individual tax return. You have the following options for your dependent care expenses:

- Use your Flexible Spending for your dependent care expenses and realize the immediate tax savings. Any reimbursement from your FSA results in a dollar-for-dollar reduction in eligible expenses for the tax credit.
- Use the dependent care tax credit on your tax return. (See worksheet to estimate whether this option or Flexible Spending will provide a greater savings.)

Total Annual Reduction

$

(Annual maximum: Married, filing separately = **$2,500** per year. Others = **$5,000** per year. Cannot be more than your earned income or your spouse's earned income, whichever is less.)

I choose to be reimbursed from my Flexible Spending account(s) for qualified expenses incurred during the period from_______________, 20______, to _____________, 20______, according to plan guidelines for claims submittal. I understand that the total annual reductions indicated above will be withheld in equal increments from each paycheck throughout the plan year. If my elected total annual reduction exceeds my actual substantiated expenses for the period indicated above, I understand that I forfeit the excess to my employer. I release my employer from all present and future rights or claims to any sums reduced from my paycheck and used for payment of expenses through my FSA. I understand that my total annual reduction amount and my participation during the plan year may only be changed because of a change in family status. I accept responsibility for proper income tax reporting in regard to benefits reimbursed by this plan.

______________________________ Employee's Signature

______________ Date

FOR OFFICE USE ONLY	
Paycheck Reduction Amount:	
$____________ Per Check	$____________ Per Month

I choose not to participate in the Flexible Spending Account(s) at this time.

______________________________ Employee's Signature

______________ Date

Employer Authorization: ______________________________________ Date: ______________