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FLEXIBLE SPENDING ENROLLMENT FORM

NEW ENROLLMENT MID-YEAR CHANGE OPEN ENROLLMENT

A. PARTICIPANT INFORMATION (REQUIRED—COMPLETE IN FULL)

Employee name: _____ DMBA ID number: _____
 Employer name: _____

B. FLEXIBLE SPENDING ELECTIONS

HEALTHCARE ACCOUNT

Total Annual Election
\$ _____

Annual maximum = **\$2,650**

DEPENDENT CARE ACCOUNT

Total Annual Election
\$ _____

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

C. MID-YEAR CHANGE IN FAMILY STATUS (PLEASE EXPLAIN)

Change in marital status: _____
 Change in dependent status: _____
 Change in work status: _____
 Date of change in family status: _____

D. HEALTHCARE FSA BENEFIT CARD

I WANT TO RECEIVE A HEALTHCARE FSA BENEFIT CARD: I understand that by receiving a card, I may be required to "substantiate" (or verify) my eligible purchases by submitting itemized receipts to DMBA.
 I DO NOT WANT A HEALTHCARE FSA BENEFIT CARD: I understand by declining the card, I may only choose to receive one during the next open enrollment.

E. PARTICIPANT AUTHORIZATION (REQUIRED)

I choose to be reimbursed from my Flexible Spending Account(s) for qualified expenses according to plan guidelines for claims submission. I understand the total annual elections indicated above will be withheld in equal increments from each paycheck throughout the plan year. If my total annual election exceeds my actual substantiated expenses, I understand 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 Flexible Spending Account(s). I understand my total annual election amount and my participation during the plan year may only be changed because of a change in family status. I understand mid-year changes to my Flexible Spending Account(s) must be consistent with my change in family status and must be made within 60 days of the change. I understand I may not decrease my election to less than the amount already in my account(s). I accept responsibility for proper income tax reporting in regard to benefits reimbursed by this plan.

Signature: _____ Date: _____