



# Enrollment Form

## Health Care Flexible Spending Account (HCFSA) & Dependent Care Flexible Spending Account (DCFSA)

\*Company: \_\_\_\_\_

\*Participant Name: \_\_\_\_\_ \*S. S. #: \_\_\_\_\_ \*D.O.B.: \_\_\_\_\_

\*Participant Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

\*Daytime Phone # (include Ext.): \_\_\_\_\_ \*Home Phone: \_\_\_\_\_

\*Email Address: \_\_\_\_\_ *\*Denotes required information*

Enrollment Status:  Open Enrollment  New Hire  Change—Qualifying Event

### Health Care Flexible Spending Account (HCFSA) Enrollment

Qualified expenses include medical, dental, vision, OTC expenses and hearing expenses **for you and your tax dependents**. Include only your estimated expenses after reimbursement from you insurance plans in this election.

<b>Annual Salary Reduction Amount</b> (Check with your human resource representative regarding minimum and maximum annual contribution allowances)	\$ _____
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### Dependent Care Flexible Spending Account (DCFSA) Enrollment

Qualified expenses include charges for the care and well-being of a child or elder dependent while you work.  
*Dependent = a child < 13 , a child >13 if they are considered disabled (unable to provide self care) or an elder dependent.*  
**DO NOT** include medical expenses for your dependent in the DCFSA enrollment section. Please include these expenses in your enrollment for the Health Care Flexible Spending program above.

<b>Annual Salary Reduction Amount</b> (Check with your human resource representative regarding minimum and maximum annual contribution allowances)	\$ _____
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### Method of Reimbursement Selection

How do you wish NYCON to reimburse you for your claims? (select either Direct Deposit or Check)

**Direct Deposit** (there is a one time \$1.00 account set-up fee, that will be deducted from your annual election, please attach a voided check to this form)

Name of Bank \_\_\_\_\_ 9-digit routing number \_\_\_\_\_ Account # \_\_\_\_\_

**Check** (Mailed to my home address)

- I Understand:**
- I have requested tax-free paycheck deduction based on the number of paychecks I expect to receive in 2011. If enrolling during open enrollment, these deductions will start with my first paycheck in 2011. If enrolling anytime thereafter, these deductions will begin with the first paycheck after this form is submitted and approved.
  - The HCFSA and DCFSA benefits, and my rights and obligations under this plan are as specified in my company's *Program Summary*.
  - This form is a binding contract and obligates me to the rules and regulations set forth for an FSA by the IRS, and cannot be changed except as stated in the *Program Summary*.

The information furnished by me in support of this application is true and correct to the best of my knowledge. I authorize any individual or organization to release any requested information to New York Council of Nonprofits, Inc.. with respect to this specific application.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_