Flexible Spending Account
ENROLLMENT FORM

To be submitted by employer

Company Name: _____ Location: _____

Employee Name: _____ SSN: _____

Employee Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Plan Year: _____ through _____

Date of Birth: _____ Date of Hire: _____ Effective Date: _____

(or during such portion of the year as remains after the date of this agreement).

EMPLOYEE'S ELIGIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

Medical Flexible Spending Account

Full Flexible Spending Account		
$ _____		
Limited Purpose Flexible Spending Account *(i.e., vision and dental only)*		
_____		

Dependent Care Spending Account

_____		

Commuter Reimbursement Account

_____		
_____		

(1)

(2)

☐ **I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.**

☐

Employee Signature Date

Please fax or email this form to: Ameriflex **Fax:** 800.282.9818 **Email:** forms@myameriflex.com

TOLL FREE 888.868.FLEX (3539) myam

ADDITIONAL CARDS *(only applicable if your employer has chosen this option)*

If you wish to have an Ameriflex Convenience Card® issued for a spouse or dependent, please be sure your spouse

[redacted]

(1) For federal tax purposes, a spouse includes all legally married same-sex or opposite-sex spouses, regardless of state [illegible]

[redacted]

Fax: Email: