Flexible Spending Account
Health Care and Dependent Care Enrollment Form

Find your account balance at www.mybenefitspeople.com.com

PARTICIPANT INFORMATION

Full Name: _____ Social Security Number: _____
(Last, First, Middle)

Address: _____
(Street, City, State, & Zip Code)

Home Phone Number: _____ Email Address:_____

Date of Birth: _____ Date of Hire: _____

Employer: CMCSS Location: _____

Enrollment Plan Year: 2017

Annual Contribution and Compensation Reduction Agreement

The Company and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each period during the plan year (or during such portion of the year as remains).

Please designate your per pay period and annual election amount you wish to contribute to your Health or Dependent Care Spending Account for this plan year.

FLEXIBLE SPENDING ACCOUNTS

HEALTHCARE SPENDING ACCOUNT
$_____ x_____ Pay Periods = $_____ Plan Year Total
(Amount per pay period)

DEPENDENT CARE ACCOUNT
$_____ x _____ Pay Periods = $_____ Plan Year Total

PAY PERIOD: _____ WEEKLY _____ BI-WEEKLY

_____ MONTHLY _____ SEMI-MONTHLY

Office Use Only

Annual Healthcare Liability
$ _____

(Must equal total pay period deductions the participant has elected.)

Additional Comments:
_____
_____
_____
_____

AUTHORIZATION: Please read the following statements and then sign and date this form.

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care or dependent care expenses incurred in the same year will be forfeited in accordance with IRS regulations.

I understand that this authorization is irrevocable until the next election period unless I have a change in status.

I also understand that this agreement is subject to the terms of the Company's Cafeteria Plan, Healthcare Reimbursement Plan and/or Dependent Care Assistance Plan as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take this as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan (s). I further declare that I will not deduct these expenses on my federal income tax return.

_____ _____
Employee's Signature Date

Waiver of Participation

I decline to participate in the Health or Dependent Care Spending Accounts for the current plan year.

_____ _____
Employee's Signature Date

BENEFITS CONNECTION **P.O. Box 681569- Franklin, TN 37068-1569** **Toll Free Fax: 877-239-6635**
Local: (615) 224-1600 **Toll Free: 877-384-7539**