



# Dependent 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: \_\_\_\_\_ (REQUIRED) \*Denotes required info

Please cover the following dependents under my FSA or HRA (include spouse):

<u>Relationship</u>	<u>Name</u>	<u>Social Sec #</u>	<u>Date of Birth</u>	<u>Disabled?</u>	<u>Full-Time Student?</u> <i><b>Proof Required</b></i>
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1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

I verify that I can claim the above dependents and they meet the plans definition of 'dependents' under my employers Flexible Cafeteria Plan. I understand that to make any changes to above names, I must complete the proper change form. The names above can only be used for claims in 2011.

Employee Signature \_\_\_\_\_

Print Employee Name \_\_\_\_\_ Date \_\_\_\_\_

*Please complete and return to your plans coordinator*