



# FlexDirect

## Flexible Spending Account Enrollment Form

										Social Security Number											
First Name										MI		Last Name									
Address																					
City										State											
Day Phone										Zip Code											
E-Mail																					

**Need help deciding how much to elect or how much you will save using a Flexible Spending Account?  
VISIT OUR WEBSITE: [www.flexdirect.adp.com](http://www.flexdirect.adp.com)**

I have reviewed the terms of my employer's Plan and I understand that I may elect coverage under either or both of the accounts below, subject to the terms of the Plan, for the Plan Year \_\_\_\_\_.

<b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b>	CONTRIBUTION PER PAY PERIOD	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR	YOUR ANNUAL ELECTION
	\$ [ ] , [ ] [ ] [ ] . [ ] [ ]	X [ ] [ ]	= [ ] , [ ] [ ] [ ] . [ ] [ ]
CANNOT EXCEED \$5,000 PER HOUSEHOLD			
<b>HEALTH CARE FLEXIBLE SPENDING ACCOUNT</b>	CONTRIBUTION PER PAY PERIOD	NUMBER OF PAY PERIODS REMAINING IN PLAN YEAR	YOUR ANNUAL ELECTION
	\$ [ ] , [ ] [ ] [ ] . [ ] [ ]	X [ ] [ ]	= [ ] , [ ] [ ] [ ] . [ ] [ ]

I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the current Plan Year noted above will be forfeited.

I hereby make the following certifications when using the FlexDirect Card provided to me upon enrollment in the plan:

- I certify that my use of the Card will comply with the terms and conditions of the cardholder agreement ("Agreement") received with the card.
- I certify that all expenses charged on the Card will qualify as reimbursable under my Plan Documents, will be incurred only for me or my eligible dependents, and will not be reimbursed and are not reimbursable through any other means, including my or my dependent's insurance plans.
- I certify that I shall not claim a federal income tax deduction or credit for any expenses charged on the Card.

**I shall keep all receipts and other documentation related to expenses charged on the Card. Upon request, I will immediately fax or mail the required documentation of expenses to the Plan Administrator.**

**I acknowledge and agree that use of the Card in violation of this enrollment agreement or the Agreement may result in the invalidation and forfeiture of the Card.**

If the Plan Administrator determines that an expense I charged on the Card was not a qualified expense under the Plan Documents, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under this Plan in order to reimburse the unqualified expense.

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

\_\_\_\_\_  
Date

Employer Section

ADP FSA Client ID \_\_\_\_\_ Employee ADP Company Code \_\_\_\_\_ Effective Date of Employee Election \_\_\_\_\_