David K. Young Consulting
BENEFIT CONSULTING & ADMINISTRATION

Enrollment Form

Employer:	
Participant Effective Date:	Date of First Payroll:

Employee Information

First Name* | Last Name* | SSN*

Address* | Apt Number

City | State | Zip

Phone Number* | Email Address* | Date of Birth*

Additional Debit Card – *please complete information if you would like a dependent to receive an additional card.*

Dependent Name | Date of Birth | SSN

Annual Elections

I request the following to be deducted from my pay pre-tax:	Per Pay Period Election	Number of Pay Periods	Annual Election
Healthcare FSA (Max $3,200)	$		$
Dependent Care Account (Max $5,000)	$		$

I UNDERSTAND THAT:

(1) If Flexible Spending Accounts for either/both Health or Dependent Care benefits are elected under this Plan, the elected amounts will be deducted from each paycheck pre-tax and held in a separate account.
(2) I cannot change or revoke this agreement at any time during the plan year unless I have a qualifying event as defined by the Plan and the Internal Revenue Code.
(3) All funds must be claimed according the terms of the Plan and within specified timeframes. All unused funds will be forfeited at the end of the Plan Year and at termination of employment.
(4) This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement to such plan(s). By signing this form, I agree to the terms and procedures of the Plan (Please see your SPD for full details).

I wish to participate in the Plan and have indicated my election above. I understand and will abide by the terms of this agreement.

☐ **I waive coverage for this plan year.**

EMPLOYEE SIGNATURE | DATE