

Flexible Spending Accounts ENROLLMENT FORM



Employer Name _____ Effective Date of Participation _____

Employee Name (Last, First, MI) _____ SSN _____

Employee Street Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____ Date of Birth _____

Payroll type (Choose one): _____ Number of payroll deductions remaining: _____
 W=weekly, B=Bi-weekly, S=Semi-monthly, M=Monthly (If enrolling mid-year, how many payroll periods remain.)

I hereby agree that my cash compensation (salary) will be reduced by the amounts set forth below for each pay period during the Plan Year (or during such portion of the year as remains after the date of this agreement). Such reductions, considered as Elective Contributions under the Plan, shall commence with my paycheck dated ____ / ____ / ____.

BENEFIT ELECTIONS

	Pre Tax Deduction (per deduction period)	Total Plan Year Deductions (annualized amount)
Transit Reimbursement Account:	\$ _____	\$ _____
Parking Reimbursement Account:	\$ _____	\$ _____
TOTALS:	\$ _____	\$ _____

The Transit / Parking Benefit is a monthly benefit. You can make changes each month if necessary. All changes must be sent to EBS by the 20th of each for the following month New, Change or cancel deduction amount.

AUTHORIZATION: I certify the above information to be correct I hereby authorize the deduction.

Authorizing Signature _____ Date _____

EMPLOYEE BENEFIT SPECIALISTS, INC.
 PO Box 11657
 Pleasanton CA 94588

Fax this form to: (925) 460-3920
 By the 20th of the month for the following month.