

**DEPENDENT CARE (CHILD CARE)
FLEXIBLE SPENDING ACCOUNT ELECTION FORM**

I have read the information on the Dependent Care Flexible spending Account. I understand that I have the option to reduce my salary to reimburse myself for dependent care expenses I may incur in the coming year.

I understand that I may elect to reduce my salary up \$5000 per year for the Dependent Care Flexible Spending Account for the Plan Year ending December 31, _____. On the back of this form is a Dependent Care Account Worksheet to help you estimate your expenses. **NOTE: ANY AMOUNT DEDUCTED DURING THE PLAN YEAR, FOR WHICH CLAIMS ARE NOT MADE, WILL BE FORFEITED.**

I elect to reduce my salary by \$_____ per period (10, 12, 26 pay periods). This amount will reduce my yearly salary by \$_____ for the period of January 1, _____ through December 31, _____.

I understand that I will not be permitted to change this election until January 1, _____ except for 30 days after the following changes in circumstances:

Marriage or Divorce

Birth, Adoption, or Death of a child

The Death or Change in Employment Status of my Spouse

Finally, I understand that if I should terminate employment before December 31, _____ my salary reduction election will cease to be effective on the day I terminate my employment.

Date

Signature

Social Security Number

Name Printed

Department

Received By

HEALTH CARE ACCOUNT WORKSHEET

To help you estimate your eligible health care expenses, look at the list below and fill in the expenses you think you will have. You can add the estimated costs and deposit any part of that amount into your Health Care Account

	Estimated Cost
Qualified day care center:	\$ _____
Nursery school:	\$ _____
Before-school	\$ _____
Summer day camp:	\$ _____
Babysitter while you are at work:	\$ _____
Housekeeper whose duties include day care:	\$ _____
Other:	
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
	Total: \$ _____