Benefit Administration by Design LLC

Enrollment Form

Participant Information

_____ _____
Name: Last, First & Middle Initial *Social Security Number*

_____ ☐ Male ☐ Female | ☐ Married ☐ Single
Date of Birth

Home Address

_____ _____
Street Address *City, State, Zip*

_____ _____
Contact Number *Email Address*

Benefit Information

_____ _____
Employer Name *Date of Hire*

_____ _____
Plan Start Date *1st Payroll Deduction*

Enrollment(s)

Plan Type	Employee Annual Election	Employer Annual Contribution
FSA	$	$
Dependent Care FSA	$	$
Limited Purpose FSA	$	$
HRA	$	$
HSA	$	$

Dependent Enrollment(s)

Last Name	First Name	SSN	Relationship	DOB	Gender

Authorization

I certify the above information is true to the best of my knowledge and that all children for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws.

Furthermore, I agree that the IRS regulations state four conditions: (1) any expense I/we incur must be within the plan year; (2) any expenses I/we incur must not be covered by any other sources, such as insurance; (3) I/we must provide proper documentation to receive payment; (4) I/we cannot change or revoke elections during the plan year unless there is a specific change in status and/or my employer allows such changes. Please see *Summary Plan Description* for details.

_____ _____
Employee Signature *Date*