FIRST
Service Administrators, Inc.

FLEXIBLE SPENDING ENROLLMENT FORM

LAST NAME	FIRST NAME	MI	TELEPHONE (HOME)	DATE OF BIRTH	HIRE DATE	SOCIAL SECURITY NUMBER
MAILING ADDRESS:	CITY	ST ZIP	TELEPHONE (WORK)	E-MAIL ADDRESS		

COMPANY NAME:	CHECK THE APPROPRIATE BOX(S):	MARTIAL STATUS:
Bulloch County Board of Commissioners	☐ I AM ENROLLING IN THE HEALTH CARE SPENDING ACCOUNT	☐ SINGLE
	☐ I AM ENROLLING IN THE DEPENDENT CARE SPENDING ACCOUNT	☐ MARRIED, FILING JOINTLY
EFFECTIVE DATE:		☐ MARRIED, FILING SINGLE

LIST ALL OTHER ELIGIBLE FAMILY MEMBERS LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER M or F	RELATIONSHIP
					[blank]	[blank]
					[blank]	[blank]
					[blank]	[blank]
					[blank]	[blank]
					[blank]	[blank]
					[blank]	[blank]

Please indicate the amount you wish to contribute to the Health and/or Dependent Care Spending Account. The yearly maximum contribution for a Health Care Spending Account is $3,000.00. The yearly maximum contribution for Dependent Care Account is $2,500.00 for filing status single or $5,000 for filing jointly.

Health Care Spending Account Election for 2011:
I wish to participate in the Health Care Spending Account and authorize my employer to deduct $_____each payperiod on a pretax basis.

Dependent Care Spending Account Election for 2011:
I wish to participate in the Dependent Care Spending Account and authorize my employer to deduct $_____each payperiod on a pretax basis.

Signature:
I have indicated my Health and/or Dependent Care Spending Account election for 2011. I understand that I cannot make any changes to this election unless I have an eligible family status change, and that I must notify my employer of such status change within 60 days of the event.

EMPLOYEE SIGNATURE	DATE