

Mercy Hospital - Port Huron Flexible Spending Account Election Form

Personal Data

Employee Name: _____ SSN: _____

Address: _____

 City State ZIP

Phone Number: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Employment Status: Full Time Part Time

Hire Date: _____ Effective Date: _____

Election Information

I elect to participate in the following reimbursement account(s) and authorize the amount(s) below to be deducted from each of my paychecks:

Health Care Reimbursement Account (contribute \$5 to \$192 per pay)

\$ _____ x _____ = \$ _____
 per pay period No. of pay periods Total Annual Election

Dependent Care Reimbursement Account (contribute \$10 to \$192 per pay)

\$ _____ x _____ = \$ _____
 per pay period No. of pay periods Total Annual Election

Deduction Authorization

I authorize Mercy Hospital to reduce my earnings from my effective date by the amount(s) indicated above. Funds deposited into my Health Care and/or Dependent Care Flexible Spending Account(s) will be available to pay for eligible expenses during the plan year. The plan year begins January 1 and ends December 31. I will have until March 31 of the following year to submit expenses incurred during the plan year. I understand that Internal Revenue Service rules required that I forfeit unused account balances.

Employee Signature: _____ Date: _____