

**Section 125
FLEXIBLE SPENDING ACCOUNTS**

**OEM America®
330 Roberts Street
East Hartford, CT 06108
(860) 528-5555**

EMPLOYEE ENROLLMENT FORM

Employer		Group No.		Effective Date
Employee's Name (Last, First, Middle)				Social Security No.
Street Address		City	State	Zip Code
Date of Birth	Sex	Marital Status	Date Employed	Occupation
Annual Salary		Payroll Frequency		Reduction Start Date

DEPENDENT INFORMATION

FLEXIBLE SPENDING REDUCTIONS

I request my salary reduced as follows:

			Per Paycheck	Annual
Spouse Name (First, MI)	Date of Birth	Employee Contributions	\$ _____	\$ _____
Dependent Name (First, MI)	Date of Birth	Unreimbursed Healthcare Expenses	\$ _____	\$ _____
Dependent Name (First, MI)	Date of Birth	Dependent Care Expenses	\$ _____	\$ _____
Dependent Name (First, MI)	Date of Birth	Total Authorized Reductions	\$ _____	\$ _____

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge. I understand that the Flexible Spending reduction will be in effect for the plan year and cannot be revoked unless I experience a change in family status. I understand that any amount remaining in my FSA account, not used for eligible expenses incurred during the plan year, will be forfeited in accordance with the current plan provisions and tax laws. I further understand that my social security benefits may be slightly reduced.

SIGNATURE _____ DATE _____

DECLINATION OF PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline to participate.

SIGNATURE _____ DATE _____