



**Flexible Spending/Dependent Care Account Enrollment Form**  
**Enrollment Period: October 1, 2012- December 31, 2012**

Return completed form by Friday September 28, 2012 to:  
 Sue Munchbach, Town Payroll Administrator, Treasurer's Office  
 Tracey White, School Payroll Administrator, School Administration

**\* REQUIRED FIELDS \***

**Town of Dedham, Massachusetts**

<b>*Employee First Name:</b>		<b>*MI</b>	<b>*Employee Last Name:</b>	
<b>*Social Security Number:</b>			<b>*Address Line 1:</b>	
<b>Address Line 2:</b>		<b>*City:</b>	<b>*State:</b>	<b>*Zip:</b>
<b>*Phone Number:</b>		<b>Cell Phone Number:</b>		
<b>*Email Address:</b>		<b>*Birth Date:</b>	<b>* Gender:</b>	

**DEPENDENTS TO BE COVERED**

<b>*First Name</b>	<b>MI</b>	<b>Last Name (If Different)</b>	<b>*S.S. # (Required)</b>	<b>*Date of Birth</b>	<b>*M/F</b>	<b>*Relationship</b>

**PLAN YEAR ELECTION**

I authorize the Town of Dedham to deduct a pre-tax contribution from my compensation for the following benefits:

Flexible Spending Account \*Annual Election \$ \_\_\_\_\_

Dependent Care Account \*Annual Election \$ \_\_\_\_\_

\* Indicates the total amount you will be contributing each plan year

In addition to your annual election, there is a \$2.75 monthly fee that you will contribute on a pre-tax basis via payroll deductions throughout the plan year.

**AUTHORIZATION OR WAIVER OF PARTICIPATION**

\* I request to participate in the benefits indicated above. I understand that my elections indicated are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan.

Under penalty of perjury, I agree to use the debit card solely for the purchase of eligible expenses. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account. I understand that these expenses cannot be claimed on my income tax return. By signing this form I hereby authorize my employer to deduct any ineligible expenses paid for with the *Choice Strategies Card™* from my paycheck. I understand that any unauthorized use may result in the loss of my *Choice Strategies Card™*.

I elect to participate in the *Choice Strategies* FSA/DCA plan

**By signing below I hereby authorize the release of claim information to my employer, their broker, and *Choice Strategies*:**

 \* Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_