Dependent Care Benefit Enrollment Form

Please complete this form to enroll in the Dependent Care Flexible Spending Account (FSA) benefit program. This form is designed for printing and physical signature.

1. Employee Information

Employee Full Name:	
Employee ID / SSN (Last 4 digits):	
Department / Division:	
Email Address:	
Phone Number:	

2. Eligible Dependent Information

List dependents for whom these care services will be provided (must be under age 13, or a qualifying disabled dependent).

Dependent Name	Date of Birth (MM/DD/YYYY)	Relationship to Employee

3. Benefit Election & Payroll Deduction

Total Annual Election Amount ($):	
Number of Pay Periods Remaining:	
Deduction Amount Per Pay Period ($):	

4. Dependent Care Service Provider Information

Provide information for the primary care provider (if known at this time).

Provider / Facility Name:	
Provider Tax ID (TIN) or SSN:	
Provider Address:	

5. Authorization and Signatures

By signing below, I elect to participate in the Dependent Care FSA. I authorize my employer to redirect the designated amounts from my paycheck on a pre-tax basis. I understand that these funds are subject to IRS regulations, including the "use-it-or-lose-it" rule.

Employee Signature (Print & Sign):	
Date (MM/DD/YYYY):	
HR Representative Signature (Office Use Only):	
Date Processed (Office Use Only):	