# UNION HOSPTIAL
# DEPENDENT CARE FLEXIBLE SPENDING ENROLLMENT FORM 2017

Employee Name_________________________________________ID#___________
Department_______________________Daytime Phone_______________________

**$5,000 Maximum per year**

**Number of Dependent Children_____**

| Name of Child | Date of Birth |
|---|---|
| _____________________ | _____________ |
| _____________________ | _____________ |
| _____________________ | _____________ |
| _____________________ | _____________ |

**Current provider of Child Care__________________________________________**

**Note:** Only child care for children under the age of 13 is eligible for reimbursement.

**I herby authorize Union Hospital to reduce my earnings for the 2017 plan year by $_________ per pay (x 24 pays) for a total of $_________ for deposit into my Dependent Care Spending Account to make this money available to me for reimbursement of out-of-pocket dependent care expenses.**

**I understand that I will forfeit any unused balance in my account at the end of the plan year. I also understand that I cannot change my plan participation unless I have a change in status, as defined by the Internal Revenue Code Section 125.**

**Signature_______________________________________________Date__________________**

**Note: Salary reductions are credited to your account on a per paycheck basis. Your salary reduction is made on a pre-tax basis, in accordance with the IRS Section 125 guidelines.**