UNION HOSPITAL.
DEPENDENT CARE FLEXIBLE SPENDING ENROLLMENT FORM 2019

Employee Name ____ID#________________________

Email Address____Daytime Phone_______________

$5,000 Maximum per year

Name of Dependent Child(ren) **Date of Birth**

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

Current provider of Child Care ____

Note: Child care for children under the age of 13 is eligible for reimbursement.

I hereby authorize UNION HOSPITAL. to reduce my earnings for the 2019 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 qualified 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 qualified change in family status, as defined by the Internal Revenue Code Section 125.

I authorize my employer to withdraw the amount listed above for the direct deposit into my FSA.

Signature____**Date**______________________

Please provide me with the following number of Flexible Spending Debit Cards ________

Bank Account Information

Bank Name ____

Routing Number ____

Account Number ____

Account Type (Circle One) Checking Savings *****Attach a copy of a voided check *****

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