FLEXIBLE SPENDING ACCOUNT (FSA) FORM

JANUARY 1, 2012 – DECEMBER 31, 2012

INSTRUCTIONS: THIS FORM MUST BE COMPLETED AND RETURNED *EVEN IF* YOU ARE *NOT* ENROLLING.

☐ **I WISH TO ENROLL IN THE CONFERENCE FSA** ☐ **I DO NOT WISH TO ENROLL IN THE CONFERENCE FSA**

PLEASE COMPLETE ENTIRE FORM AND RETURN IT TO *THE CONFERENCE TREASURER'S OFFICE*.

Your Name _____ Social Security # _____

Street Address _____ Date of Birth _____

City _____ State _____ Zip Code _____

Work # _____ Home # _____

Fax # _____ E-Mail Address _____

Payroll Schedule: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

PLEASE LIST DEPENDENTS YOU WILL BE SUBMITTING CLAIMS/RECEIPTS FOR.

Family **First, Middle Last**

1. Dependent _____ Relationship _____ Birth Date _____
2. Dependent _____ Relationship _____ Birth Date _____
3. Dependent _____ Relationship _____ Birth Date _____
4. Dependent _____ Relationship _____ Birth Date _____
5. Dependent _____ Relationship _____ Birth Date _____

PRE – TAX PAYROLL DEDUCTIONS OPTIONS

PRE-TAX INSURANCE PREMIUM CONTRIBUTION (Not Reimbursable) $ _____

FLEXIBLE SPENDING ACCOUNTS (Reimbursable)

HEALTH CARE SPENDING ACCOUNT (check one) Maximum election of $4,000.

☐ I wish to have $ _____ withheld annually at $ _____ per pay for eligible out of pocket Health Care Expenses for the plan year January 1, through December 31.

☐ I do not wish to participate in the Health Care Spending Account this year.

DEPENDENT (DAY) CARE SPENDING ACCOUNT (check one) Maximum election of $5,000.

☐ I wish to have $ _____ withheld annually at $ _____ per pay for eligible out of pocket Dependent Care Expenses from January 1, through December 31. I understand that if I am married and filing a separate tax return, a lower maximum applies.

☐ I do not wish to participate in the Dependent Care Spending Account.

I understand that these accounts may only be used for my dependents as defined under the plan and that my choices above must remain in effect for the entire plan year unless I have a change in family status. I also understand that any unused balances in either account at the end of the plan year shall be forfeited. I hereby give my employer permission to reduce my salary by the above elected amount(s).

_____ _____

Signature ***Date***

PO Box 6247 ♦Grand Rapids, Michigan 49506 ♦Phone (616) 459-4503 ♦ Fax (616) 459-0191

Copy 1 Conference Treasurer ♦ Copy 2 Local Church Treasurer (Payroll File)