



Flexible Spending Account Enrollment Form Franklin County Schools

Employee Information

Social Security Number	Date of Birth	Date of Hire	Phone Number
Last Name	First Name	Home Address	
City, State	Zip	Email Address	

Account Information

	Pay Period Election	Annual Election
Healthcare FSA	\$	\$
Dependent Care FSA	\$	\$
Total	\$	\$

I hereby certify that I have examined this affidavit and to the best of my knowledge and belief, it is true, correct and complete. I apply for the options listed above and authorize payroll deductions in connection with my elections. I understand the benefit options I have elected will remain in force throughout the plan year, unless I have a change in family status.

Signature _____
Date

Waiver of participation: I have been informed of the terms of the above referenced Flexible Benefit Plan, and elect not to participate at this time. I understand that this waiver will remain in effect for the current plan year and that I may elect to participate in later plan years by completing an election form during the election period prior to each plan in which I wish to participate.

Signature _____
Date

For Employer Use Only

FSA Effective Date	Franklin County Schools Employer Name
Date of First Payroll Deduction	Signature of HR/Benefits Approval
Payroll Calendar (i.e. Biweekly, Monthly, etc)	Date of Approval