



FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Account Number N-70214-4 / N-93175-4

Employee Information

Your name (last,first,middle initial)		Social security number/ID number	
Address (street)			
City	State	Zip code	
Date of birth	Your email address		
<input type="checkbox"/> male <input type="checkbox"/> female			
Spouse's name	Spouse's social security number/ID number	Spouse's date of birth	

I want to participate in our Flexible Spending Account (FSA)

Reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand this reduces my wages for Social Security purposes, and may reduce my Social Security disability and retirement benefits. I understand I will not earn interest on my contribution. I also understand that once I have made this election, I can only change it during the election period prior to the next plan year, or if there has been a qualifying change in my family's status, employment as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation, or at the end of any plan year or applicable grace period, will be forfeited. I certify that I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not include them as itemized deductions or as a tax credit on my personal income tax returns.

NOTE: Changes in election allowed due to a qualifying change in family status must be made no later than 30 days after the date of the qualifying change in status.

Frequency of your paychecks: bi-weekly

	Health Care	Dependent Care	
*Total Annual Election:	\$ _____	\$ _____	Note: Dependent Care spending accounts are not medical spending accounts for a participant's spouse or children. It's day care (baby-sitting) for children or elderly dependents.
Pay periods remaining:	÷ _____	÷ _____	
Bi-weekly payroll deduction:	\$ _____	\$ _____	

*The annual election should be based on the number of pay periods remaining.

I decline to participate in our FSA

I realize that if my election form is not received by the end of the election period, I have declined to participate by default. I understand that if I will not be eligible to participate again until the following plan year unless there has been a qualifying change in my family's status or employment.

I verify that the above information represents my election regarding my participation in the Flexible Spending Account program of Polk County for the plan year beginning July 1, 2010 and ending June 30, 2011.

Employee telephone number _____

(Signature)

Date signed

Date signed **must** be prior to effective date of the plan year. If change of status occurs during plan year, date signed **must** be prior to pay period in which the above listed contributions will go into effect.

If you would like your reimbursements deposited into your bank account, complete the following information. If you are currently enrolled in the direct deposit option, you do not need to complete a new form, information will roll-over with each renewal.

Social security number/ID number _____

Banking Information **Checking Account Information** or **Savings Account Information**

new set-up* change current set-up* cancel current set-up

Financial Institution	City
State	Zip
Bank transit/ABA number	Account number

I hereby authorize Principal Life Insurance Company to credit my FSA Reimbursement in the bank listed above. This authorization is to remain in full force and effect until I send written notice of a change or cancellation.

Signature	Dept/office name	Date
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Your account will be prenoted for one pay period. The prenote process is done to detect any problems with your bank transit and account numbers. You will receive a regular FSA reimbursement check for the prenote pay period.

Direct Deposit Choices and Information

Your First Deposit and Account Changes

- New direct deposit participants and those who change banks or accounts will receive one regular check before direct deposit takes effect.
- This “prenote” process allows FSA to verify the new account or bank to ensure safe and accurate deposits.
- If you change or close your account(s) complete a new Direct Deposit Authorization form
- Make your account changes as soon as possible to ensure that your funds are deposited correctly. Check the deadline schedule.
- Direct deposit transactions occur on the third business day following reimbursement.

Employer to Complete this Section

	Location/unit
Beginning pay period date (Refer to Quick Reference Guide)	Reason for change <input type="checkbox"/> initial request <input type="checkbox"/> change

Deductions are taken out 24 times during the year. Please see schedule below to determine the number of pay periods remaining in the plan year.					
Pay Date	Pay Period Remaining	Pay Date	Pay Periods Remaining	Pay Date	Pay Periods Remaining
07/09/2010	24	11/12/2010	16	03/18/2011	07
07/23/2010	23	11/26/2010	15	04/01/2011	06
08/06/2010	22	12/10/2010	14	04/15/2011	05
08/20/2010	21	12/24/2010	13	04/29/2011	NA
09/03/2010	20	01/07/2011	12	05/13/2011	04
09/17/2010	19	01/21/2011	11	05/27/2011	03
10/01/2010	18	02/04/2011	10	06/10/2011	02
10/15/2010	17	02/18/2011	09	06/24/2011	01
10/29/2010	NA	03/04/2011	08		