



City of Lincoln Park

2017 Flexible Spending Account Enrollment Form

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION

Participant First Name: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ / _____ / _____

Address: _____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payments are only sent via e-mail)

MEDICAL REIMBURSEMENT ACCOUNT

I elect to participate (not to exceed IRS limit of \$2,550)

\$ _____ per pay x 26 (# of pays in 2017) = \$ _____ Annually (do not round)

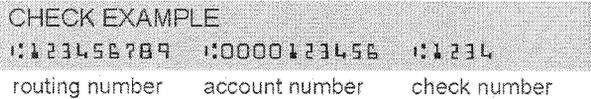
DEPENDENT CARE ACCOUNT

I elect to participate (not to exceed \$5,000 or \$2,500 if married filing separately)

\$ _____ per pay x 26 (# of pays in 2017) = \$ _____ Annually (do not round)

DIRECT DEPOSIT (reimbursements, direct deposit only)

Checking account **OR** Savings account



Financial Institution (name of bank): _____

Routing Number (always 9 digits): _____ Account Number: _____

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status. I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____