

City of Lynchburg Flexible Spending - Enrollment Form Section 125 Health and Dependent Care Account

Employee Name (First, Last) _____

Social Security Number: ____ - ____ - ____

Date of Birth: ____ / ____ / ____

Date Hired: ____ / ____ / ____

Home (street) Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____

Email: _____

Election / Payroll Deduction Section

Healthcare Account I elect to contribute \$ _____ Maximum \$2500.00

Dependent Care Account I elect to contribute \$ _____ Maximum \$5000.00
((\$5000 per family or \$2500 if married filing separate returns)

Dependent Name	Relationship	Social Security Number	Date of Birth

*The amount(s) I have elected will be taken from my pay in equal installments on a pretax basis. I understand that if I fail to submit eligible claims for entire amount elected, I forfeit any remaining balance. The election(s) will continue throughout the Plan Year until I notify Human Resources in writing of a qualifying Status Change / Event.

*Employee signature: _____ Date: _____

Employer to Complete or enrollment cannot be processed:

Plan Year Start Date	Plan Year End Date	First Payroll Date	Number of Pay Periods	Department
/ /	/ /	/ /		