



Flexible Benefit Plan Enrollment Form

Employee Name:		Soc. Sec. No.:		
Home Address:				
City:		State:		Zip:
Department:		Work Phone:		Home Phone:
Spouse's Name:			Spouse's Date of Birth:	
Other Dependents:	Name	Date of Birth	Name	Date of Birth
	1.		2.	
	3.		4.	

As the employee of James City County noted above, I do hereby elect to participate in the James City County Flexible Benefit Plan and to be reimbursed for the expenditures indicated below, all of which I will incur during the above Period of Coverage. Each of the declared amounts indicated below are reimbursable and satisfy the requirements under the Flexible Benefit Plan as described in the James City County Flexible Benefit Plan, Plan Document.

I hereby authorize James City County to reduce my gross compensation each pay period by an amount equal to the total of these expenditures effective _____ through June 30, _____.

Health Care Reimbursement Account: \$ _____ per pay period \$ _____ Annually
(_____ pays/year, filled by HR only)

Dependent Care Reimbursement Account: \$ _____ per pay period \$ _____ Annually
(_____ pays/year, filled by HR only)

TOTAL AUTHORIZED SALARY REDUCTIONS:

\$ _____ per pay period \$ _____ Annually

If, at the end of the Plan Year, the total of my declared adjustment in compensation exceeds my substantiated incurred expenses, I recognize that James City County will retain the difference in the amounts. I further acknowledge that the elections made in this Enrollment Form may not be changed until the beginning of the next Plan Year unless there is a change in my family status.

All reimbursement from the Plan will be deposited to your authorized checking or savings account. You must complete and submit this form along with the Flexible Spending Account Direct Deposit Authorization Form.

I hereby certify that I have examined this enrollment form and to the best of my knowledge and belief, it is true, correct and complete.

SIGNATURE: _____ DATE: _____