

HEALTH CARE & DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

ENROLLMENT FORM

Name: Last, First, Middle Initial

Social Security Number

Street Address

DOB

City

State

Zip Code

Based on your estimates, elect the amount you wish to contribute to the Health Care Spending Account and/or the Dependent Care Spending Account this year.

HEALTH CARE ACCOUNT

Per pay Period Amount \$ _____

Annual Goal Amount \$ _____

Health Care FSA maximum contribution is \$2,000

DEPENDENT CARE ACCOUNT

Per pay Period Amount \$ _____

Annual Goal Amount \$ _____

The IRS has established limits that can be contributed to the Dependent Care Spending Account. (\$5,000 or \$2,500 if married and filing a separate income tax return)

Health Care – Automatic Reimbursement Authorization

I authorize United HealthCare to make Automatic Reimbursement payments from my Health Care FSA for expenses submitted to, but not payable by, my medical plan. I certify that expenses to be automatically reimbursed through my FSA will be incurred by me (and/or my spouse and/or my eligible dependents) and will not be reimbursed by another plan. I (or we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) Individual tax return.

Please read, sign and date this form:

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care or dependent care expenses incurred in the same year, will be FORFEITED accordance to IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status as defined by the IRS and Sherwin Alumina.

Signature

Date