Sec. 125
HCR & DCR with Limited HCR Enrollment IRS Section 125

Your Flexible Benefit Specialists

Health Care Reimbursement (HCR) Account & Dependent Care Reimbursement (DCR) Account

I. Employer Name

Your Name (last, first, middle)	Social Security Number		Date of Birth	Gender	Marital Status
Mailing Address	City	State	Zip	( ) Day Time Phone Number	
email address:					

II. List Dependents *(If any)*

Spouse's name (last, first, middle)	Date of Birth	Dependent's name (last, first, middle)	Date of Birth
Dependent's name (last, first, middle)	Date of Birth	Dependent's name (last, first, middle)	Date of Birth

III. Enrollment Election *(check which plans you want and complete information)*

- ☐ Yes, I elect to participate in a Dependent Care Reimbursement (DCR) Account: Annual Election: $__________________
- ☐ No, I do not elect to participate.

Name of Dependent Care Provider:	Tax ID # or SS #

- ☐ Yes, I elect to participate in a Health Care Reimbursement (HCR) Account: Annual Election: $_________________ **OR**
- ☐ Yes, I elect the **LIMITED** Health Care Reimbursement (LMT). I **or my spouse** are eligible to contribute to an HSA bank account OR I am part time, not eligible to enroll in my employers group health plan but eligible to enroll in this LMT Plan: Annual Election: $__________
- ☐ No, I do not want to participate.

IV. Certification

I certify that all the information on this form is correct. I understand that: Any amount remaining in my Health Care Reimbursement (HCR) and/or Dependent Care Reimbursement (DCR) and/or Limited Health Care Reimbursement (LMT) accounts at year end will be forfeited in accordance with current plan provisions and the IRS tax laws; and that all plan deductions are in effect for the full plan year and cannot be changed or stopped unless I experience a change in family or employment status.

Employee's Signature: ____ Date: ____________________

Return completed Enrollment Form to your Benefit Department

Employer Use REQUIRED	Date of Hire: / /	Effective Date: / /	# of Paychecks remaining this Plan Year:
Payroll Cycle: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly ☐ Monthly	Pay Date of First Deduction: / /
Health Care Deduction Per Pay Period $		Dependent Care Deduction Per Pay Period $	
☐ Mid-Year Status Change (See plan document for list of qualifying events) Explain:			

Note to employer Representative: Please retain the original copy of this form for you records and provide a photocopy to ABS.

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