Ancon Construction
FLEXIBLE SPENDING ACCOUNT
ENROLLMENT / CHANGE FORM

PHP

APPLICANT INFORMATION

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	LOCATION

TYPE
☐ New Enrollment ☐ Change

If change, please mark one of the following:
☐ Marriage ☐ Divorce ☐ Birth/Adoption of Child
☐ Change of Spouse's Employment ☐ Death of Spouse or Child
☐ Other: _____

DATE OF HIRE

EMAIL ADDRESS

PLEASE INDICATE YOUR DESIRED BENEFIT OPTIONS BY CHECKING THE APPROPRIATE BOX

☐ HEALTH CARE FLEXIBLE SPENDING ACCOUNT

My taxable compensation is to be reduced for qualifying health care expenses in the amount of:

$_____ = _____24_____ /$_____
Annual Election # of Pay Periods Per payroll deduction

Note: The annual election must equal the per payroll deduction multiplied by the number of pay periods for the year

Maximum $3,400 per year

INDICATE YOUR TOTAL FOR ANNUAL ELECTIONS (HEALTH CARE TOTAL)	**$**_____

PARTICIPATING - By signing my name below, I agree or understand that:
This election is irrevocable during the plan year. The only exception to this is if I have a qualified change in family status. Reduced amounts of taxable compensation not used to pay eligible benefits during the plan year will be forfeited. My employer may change or suspend the reduction of compensation if the Internal Revenue Service, through legislation or restrictive regulation, limits or prohibits salary reduction as currently permitted under Section 125 of the Internal Revenue Code. Compensation contributed into one of the two Flexible Spending Accounts cannot be transferred and used for expenses in the other Flexible Spending Account. **Employees with multiple group health and/or dental coverage on themselves or any of their dependents cannot have claims automatically reimbursed through flex.** I agree to execute this salary reduction agreement in accordance with the master plan document. I advise PHP TPA Services that the claims I submit to PHP TPA Services. as the third party administrator for my employer's group health and flexible spending account plans, have not been reimbursed and are not reimbursable under any other health plan coverage. I will notify immediately if I become aware that any such claims are reimbursed or become reimbursable under any other health plan coverage. My Social Security benefits may be slightly reduced as a result of my election.

_____ _____
EMPLOYEE SIGNATURE DATE

WAIVER OF PARTICIPATION

This waiver will acknowledge that I have been informed of the terms of the above referenced plan. Although I am eligible in such plan, I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of the plan year for which this election is effective, but that I may decide to participate during the election period prior to each plan year.

_____ _____
EMPLOYEE SIGNATURE DATE