

Sec. 125 HCR & DCR Enrollment



IRS Section 125

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

I. Employee Enrollment:					<input type="checkbox"/> Mid-Year Status Change (See plan document for list of qualifying events) Explain:									
<input type="checkbox"/> Re-enrollment					<input type="checkbox"/> New Hire					<input type="checkbox"/> Rehire				
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)	
<input type="checkbox"/> Yes, I elect to participate in a Dependent Care Reimbursement (DCR) Account: Annual Election: \$ _____	
<input type="checkbox"/> No, I do not elect to participate.	
Name of Dependent Care Provider:	Tax ID # or SS #
<input type="checkbox"/> Yes, I elect to participate in a Health Care Reimbursement (HCR) Account: Annual Election: \$ _____	
<input type="checkbox"/> 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), 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: _____
<i>Return completed Enrollment Form to your Benefit Department</i>	

Employer Use Only	Date of Hire: / /		Effective Date: / /		Number of Paychecks This Plan Year:	
Payroll Cycle:	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Monthly	Pay Date of First Deduction: / /	
Health Care Deduction Per Pay Period \$			Dependent Care Deduction Per Pay Period \$			

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

