

Sec. 125 HCR & DCR Enrollment **IRS Section 125**



Advanced Benefit Strategies

Your Flexible Benefits Specialists

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

I. Employee Enrollment

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: required				

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 Health Care Reimbursement (HCR) Account: Annual Election: \$ _____ <input type="checkbox"/> No, I do not elect to participate.	
<input type="checkbox"/> Yes, I elect to participate in a Dependent Care Reimbursement (DCR) Account: Annual Election: \$ _____ <input type="checkbox"/> No, I do not want to participate.	
Name of Dependent Care Provider:	Tax ID # or SS #

Monthly fee for enrolling in the Plan is \$5.00 per month and it includes the debit card for Health Care Reimbursement (HCR). It is one fee no matter if you are enrolling in HCR, DCR or both Plans.

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: / /	# of Paychecks remaining 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: \$	
<input type="checkbox"/> Mid-Year Status Change (See plan document for list of qualifying events) Explain:			
<i>Note to employer Representative: Please retain the original copy of this form for you records and provide a photocopy to ABS.</i>			