Employer:
Approved by:

HIGHMARK® Delaware

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

INSTRUCTIONS:

(1) Refer to your enrollment book for help with completing this form, or see your Benefits Administrator.
(2) Please complete all applicable sections.
(3) Return this form to your company's Benefits Administrator by _____ .

CHECK ONE BOX: ☐ I am enrolling as a newly eligible person or during annual enrollment. ☐ I am requesting a change in my election.

Social Security Number	Last Name	First Name	M.I.	Date of Hire (month, day, year)	Birth Date (month, day, year)

☐ Male ☐ Female	Full Address—Street, City, State, Zip Code

Daytime Phone (include area code)	Home Phone (include area code)	E-mail Address

FLEXIBLE SPENDING ACCOUNT ELECTION. Enter the amounts you want to contribute each pay period.

Effective Date (month, day, year)	**HEALTH CARE ACCOUNT**	Amt. Per Pay: $	× No. of Payroll Deductions:	= Annualized Amount: $
Effective Date (month, day, year)	**DEPENDENT CARE ACCOUNT**	Amt. Per Pay: $	× No. of Payroll Deductions:	= Annualized Amount: $

ABOUT YOUR DEPENDENTS. (Attach additional sheet if you have more than 3 dependents.)

FIRST NAME (AND LAST NAME IF DIFFERENT)	SOCIAL SECURITY NUMBER	RELA-TIONSHIP CODE*	BIRTH DATE (month, day, year)	SEX	FULL-TIME STUDENT?	STATUS CODE**	CHECK TYPE OF INSURANCE IN EFFECT FOR DEPENDENT		
							Medical	Dental	Vision
Please check (√) type of insurance coverage in effect for YOU at right. If not applicable, put N/A. Please do not leave blank. →									
				☐ Male ☐ Female	☐ Yes ☐ No				
				☐ Male ☐ Female	☐ Yes ☐ No				
				☐ Male ☐ Female	☐ Yes ☐ No				

***Relationship Code:** SP=Spouse CH=Child OT=Other ****Status Code:** S=Full-time student age H=Handicapped person D=Totally disabled person

YOUR APPROVAL AND SIGNATURE

I AUTHORIZE MY EMPLOYER, named above, to make before-tax salary reductions for the choices I have made above. I understand that I cannot change these choices during the plan year unless I have incurred a qualified family status change as specified in the Plan Document. Changes to my election must be on account of and consistent with my family status change.

Signature Date: