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)	Employee ID	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: $_____

☐ No, I do not want to participate.

Optional Debit Card

☐ Yes, sign me up for a Debit Card. ($18.00 per year)

☐ No, I do not want a Debit Card.

My e-mail address is (required for Debit Card): _____

Check with your benefit representative to see if this is available

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: _____

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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