EMPLOYEE NAME

EMPLOYEE ID:

# HEALTH & DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CALENDAR YEAR ENROLLMENT FORM

Please indicate below the amount you wish to contribute to either your Health Care or Dependent Care Flexible Spending Account.

You can review your FSA balance at any time by logging on to www.wageworks.com

## HEALTH CARE FLEXIBLE SPENDING ACCOUNT

$ _____

Total annual contribution

*($2,750 maximum, $1,375 if married and filing separate income tax return)*

## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

$ _____

Total annual contribution

*($5,000 maximum. $2,500 if married and filing separate income tax return)*

If you are married and plan to enroll in Dependent Care Flexible Spending Account, please indicate whether you are planning to file a joint or separate income tax return this year.

☐ Joint ☐ Separate

## TOTAL ANNUAL SPENDING ACCOUNT CONTRIBUTION

$ _____

By reading and signing the statement below, I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that any unused amounts deducted from my pay for eligible health care and/or dependent care expenses will be forfeited in accordance with IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status as defined by the Internal Revenue Service.

Signature Date Extension

Washington Metropolitan Area Transit Authority