

Sec. 125 HCR & DCR with Limited HCR Enrollment IRS Section 125



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

I. 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: \$ _____ OR <input type="checkbox"/> Yes, I elect the LIMITED Health Care Reimbursement (LMT). I or my spouse are eligible to contribute to an HSA bank account OR I am part time, not eligible to enroll in my employers group health plan but eligible to enroll in this LMT Plan: 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) and/or Limited Health Care Reimbursement (LMT) 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 REQUIRED	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>			