Capital

An Independent Licensee of the Blue Cross Blue Shield Association

# DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

**Complete and return to your employer**

## Group Information

Group Name:_____ Spending Account Group Number:_____

Location Name (if applicable):_____

## Employee Information

SSN#:_____ Primary Phone:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____ Date of Birth:_____

## Account Information

**Dependent Care Flexible Spending Account:**
IRS Annual Maximum (2021 only): $10,500.00 ($5,250.00 if married and filing separate tax returns)

Effective Date_____ (To be provided by group contact)

☐ I want to contribute a total of $_____ during this plan year to my Dependent Care Flexible Spending Account.
I understand this amount will be deducted from my pay throughout the plan year.

## Signature

I have reviewed the above elections and understand my choices will remain in effect for the entire plan year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the plan year may be forfeited.

**Signature**:_____ **Date**:_____

**Employees:** Complete and return this form to your employer.
**Employers:** Save time by entering this information online at least 30 days prior to your plan start date. Sign into the Employer portal at **capitalbluecross.com**. Questions? Call Group Leader Services at 877.293.7041.

**Send via secured email only:**
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