Flexible Spending Account
Health Care and Dependent Care Enrollment

Employee Information

Social Security umber	Name (Last, First, Middle Initial)	Date of Birth *(MMIDDIYYYY)*

Telephone number	Email address
( )	

Street Address | City | State | Zip Code

Employer Information

Employer	Control umber
TW Ventures Inc.	**139064**

Annual Contribution

Complete the following section to elect the type(s) of flexible spending account plan(s) you wish to participate in and designate the annual contribution amounts.

I wish to participate in the following flexible spending account plans:

	Annual Contribution
☐ Health Care FSA	$ _____
☐ Dependent Care FSA ($5,000 maximum if single or married and filing joint federal income tax return; $2,500 if married and filing separate federal income tax returns.)	$ _____
Total Annual Contribution	$ _____

Authorization - Please read the following statements and then sign and date this form.

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred the same year **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.

Signature _____ Date _____