QVI risk solutions inc

Part I	Flexible Spending Account Enrollment Election Form			
Employer's Name		**Effective Date (Required)**	**Social Security Number**	
Employee's Last Name	**First Name**	**Middle Initial**	**Date of Birth**	**Home Phone Number ( )**
Mailing Address	**City**	**State**	**Zip code**	

Part II	Dependents		
Spouse Name	Last	First	Date of Birth
Child's Name	Last	First	Date of Birth
Child's Name	Last	First	Date of Birth
Child's Name	Last	First	Date of Birth
Child's Name	Last	First	Date of Birth

Part III Contributions	MONTHLY CONTRIBUTION AMOUNT	YEARLY CONTRIBUTION AMOUNT
A. Total health-related contributions	$_____	$_____
B. Total dependent care contributions **(Childcare and/or pre-school to age 13, and adult daycare)**	$_____	$_____
C. Total other health insurance premium contributions	$_____	$_____

I hereby certify the above information to be correct and true to the best of my knowledge and that the children or dependent on whom I will be claiming dependent expenses either reside with me in a parent-child relationship or are legally dependent on me for their support.

As an eligible employee in the above Plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I elect the benefits and designate the amounts listed above for each benefit I have selected for the Plan Year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period and Plan Year (or during such portion of the year as remains after the date of this agreement).

► _____

Applicants Signature **Date** **Applicants Full Name (please print clearly)**