QVI risk solutions inc

Part I	Flexible Spending (FSA)and Dependent Care (DCAP) Enrollment Election Form		
Employer's Name			**Effective Date (Required)**
Employee's Last Name	**First Name**	**Date of Birth**	**Home Phone** ( )
Mailing Address	**City**	**State**	**Zip code**

Part II Electing to Participate in Health FSA/and or Dependent Care ☐ **Yes** ☐ **No**

Part III If you are electing to participate in Health FSA and/or DCAP and/or Individual health premium please list family members. All family members that are considered on your IRS taxes are eligible.

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

Part IV If you have elected to participate in FSA/DCAP complete the contribution portion below.

	MONTHLY CONTRIBUTION AMOUNT	YEARLY CONTRIBUTION AMOUNT
A. Total health-related contributions **Maximum allowed to contribute is $2,500 per year.**	$_____	$_____
B. Total dependent care contributions **(Childcare and/or pre-school to age 13, and adult daycare)** **Maximum amount to contribute is $5,000 for married filing a joint return or head of household, or** **$2,500 if you are married and filing separate returns.**	$_____	$_____

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 above 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)**

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Quality, Value, and Innovation in Insured Risk and Self-Funding