

# FLEX SPENDING ENROLLMENT FORM

Aflac Benefit Services/Flex One  
1932 Wynnton Road  
Columbus, GA 31999-9950



Name: Last		First	MI	Employee ID
Employment Date	Effective Date	Office Phone		Location
				DeLand Campus
Address			City	State, ZIP

*To add family members, complete this area:*

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		

Indicate the benefits you wish to pay through tax-free salary reduction by checking the appropriate boxes and entering the necessary information below. Calculate contributions carefully as unused funds are forfeited at the end of the plan year.

FLEX Reimbursement Account		Annual Amount	Pay Period Amount
<input type="checkbox"/>	<b>Medical Expense</b> - Indicate the amount you wish to contribute. Medical expenses are limited to \$5,000. Annual amount divided by 12 if paid monthly, by 24 if paid biweekly. If for less than a year, divide annual amount by remaining pay cycles in the calendar year.	\$ _____	\$ _____
<input type="checkbox"/>	<b>Dependent Care Expense</b> - Indicate the amount you wish to contribute. Dependent care expenses are limited to \$5,000. Annual amount divided by 12 if paid monthly, by 24 if paid biweekly. If for less than a year, divide annual amount by remaining pay cycles in the calendar year.	\$ _____	\$ _____

**IMPORTANT**

- I understand that this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I understand that my Group Medical Premiums will be paid automatically through tax-free salary reduction unless waived.
- I hereby authorize my employer to reduce my gross salary before federal, state, and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved Family Status Change.
- I understand that any amount remaining in any Flex Reimbursement Account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year.
- I understand and agree that Stetson University will not incur any liability resulting from either my participation in or failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forgo my right to participate during the upcoming plan year.

Employee Signature	Date

For customer service, call 1-877-FLEX-IVR (1-877-353-9487)  
To file a Flex One® reimbursement, you must complete a Flex One® Request for Reimbursement  
<http://www.aflac.com/us/en/policyholders/ClaimForms.aspx>  
All Requests for Reimbursements can be faxed to 1-877-FLEX-CLM (1-877-353-9256).