

# CALIFORNIA INSTITUTE OF TECHNOLOGY SPENDING ACCOUNT ENROLLMENT FORM

Shaded Areas for Office Use Only		
<b>FPSO Use</b> <input type="checkbox"/> Full Cost Staff Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	Pay ID _____	<b>For Office Use Only</b> Effective Date of Coverage: _____ Reviewed/Input By: _____ Late Applicant: ___ COBRA Event: ___ Dep. Ineligible/Elig.: ___

PERSONAL INFORMATION	
Last Name: _____	First Name: _____ M.I.: _____
Street: _____	City, State, Zip: _____
Telephone (day): _____	Telephone (eve): _____
Birth Date: _____	Social Security Number: _____

REASON FOR ENROLLMENT/CHANGE		
<input type="checkbox"/> Enrollment	<input type="checkbox"/> Family Status Change (Check reason below)	<input type="checkbox"/> Address Change Only
<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Divorce, Separation or Death	<input type="checkbox"/> Relocation
<input type="checkbox"/> Marriage	<input type="checkbox"/> Change of Spouse's Employment	<input type="checkbox"/> Other
<input type="checkbox"/> Name Change	<input type="checkbox"/> Date of change _____	

SPENDING ACCOUNTS <i>(Read all Terms and Conditions of these plans carefully.)</i>		
<b>Dependent Care Spending Account (Day Care)</b>	<b>Health Care Spending Account</b>	<b>For Internal Use</b>
Enter the annual amount you want to contribute (maximum \$5,000 per year if single or married and filing jointly, \$2,500 if married and you file income tax separately).	Enter the annual amount you want to contribute (minimum \$120/maximum \$4,000 per year).	<b>DCSA</b> \$ _____ <b>Per Month</b>
\$ _____ (Annual Amount) Your contribution will be deducted from your pay in equal monthly installments.	\$ _____ (Annual Amount) Your contribution will be deducted from your pay in equal monthly installments.	<b>HCSA</b> \$ _____ <b>Per Month</b>

Signature \_\_\_\_\_ Date \_\_\_\_\_