

**WAUKESHA COUNTY
DEPENDENT CARE REIMBURSEMENT ACCOUNT
(Flexible Spending Account)**

Employee Name: _____
(Contact Phone)

Mailing Address: _____
(Street)

(City) (State) (Zip Code)

(Social Security Number) (Hire Date) (Birthdate)

Choose carefully as your election is binding for the entire Plan Year. Any unused dollars remaining in your Flexible Spending Account at the end of the Plan Year will be forfeited. Expenses/claims must be incurred during the Plan Year in order to be eligible for reimbursement. The plan year is January 1st - December 31st.

As a participant I hereby elect to participate in the Dependent Care Reimbursement Flexible Benefits Plan and therefore authorize my Employer to reduce my wages on a pretax basis during each payroll period in the following amount. I understand this election must be re-authorized each year.

Enter the amount you wish to have deducted from each paycheck. You can only have 3 changes within this schedule. The total of all months cannot exceed \$5,000 per household.	<u>Pay Date</u>		<u>Pay Date</u>		
		01/06/16--01		07/06/16--15	
		01/20/16--02		07/20/16--16	
		02/03/16--03		08/03/16--17	
		02/17/16--04		08/17/16--18	
		03/02/16--06		08/31/16--19	
		03/16/16--07		09/14/16--20	
		03/30/16--08		09/28/16--21	
		04/13/16--09		10/12/16--22	
		04/27/16--10		10/26/16--23	
		05/11/16--11		11/09/16--24	
		05/25/16--12		11/23/16--24	
		06/08/16--13		12/07/16--25	
		06/22/16--14		12/21/16--26	

\$192.30 X 26 pay dates = \$4,999.80

ANNUAL TOTAL \$

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby elect to participate in the Dependent Care Reimbursement Flexible Spending Account.

I understand that I cannot revoke or change my election amounts during the Plan Year unless there is a qualifying "Status Change." The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.

I understand that I must submit a claim and appropriate documentation for out-of-pocket Dependent Care expenses before I can be reimbursed.

Employee Signature: _____ Date: _____