Clarity | BENEFIT SOLUTIONS™

DEPENDENT CARE ACCOUNT ENROLLMENT FORM

PLEASE COMPLETE THIS FORM AND SUBMIT TO YOUR EMPLOYER

Last Name _____ First Name _____

Social Security Number _____ Date of Hire _____

Address _____ City _____

State _____ Zip _____ Phone (____) _____

☐ (Check Here if Mobile Number)

E-mail Address _____ DOB _____

Option I: Dependent Care Reimbursement Account

Enter an **ANNUAL** PRE-TAX contribution election up to maximum **$5,000**: **$_____**

Option Ii: Waiver of Tax Benefits

☐ I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

Employee Signature_____ Date_____

For Employer Use Only

Effective Date: _____

**Annual plan limits are available at claritybenefitsolutions.com/resources/plan-limits.*