



Please save your completed form or  
 "Print to PDF" before emailing to  
 benefits@providenceri.gov or faxing to  
 401-680-5457

**CDH Administration**  
 40 Commercial Way, East Providence, RI 02914  
 Email: customerservice@londonhealthusa.com  
 Phone: 401-435-4700  
 Fax: 401-435-3937

**Flexible Spending Account (FSA) Enrollment Form**

<b>Employee Information:</b>	Company	Group	Pay Freq.
Employer Name:	City of Providence		Effective Date:
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
Email Address:	Phone #:		
Date of Birth:	Social Security #:		

**Dependent/s Information:**

Dependent Name:	Relation:	Date of Birth:	Order Debit Card: <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: <input type="checkbox"/> Yes <input type="checkbox"/> No

*\* Please list additional dependents on back side of this enrollment form*

**Employee's Flexible Benefit Per Pay Deduction / Allocation:**

<b>Health Care Spending Account:</b>	
\$2,750.00 _____ Maximum Annual Contribution	Annual Contribution \$ _____
<b>Dependent Care Spending Account:</b>	
\$5,000.00 _____ Maximum Annual Contribution	Annual Contribution \$ _____
<b>Commuter Spending Account:</b>	
\$270.00 _____ Maximum Monthly Contribution	Per Pay Period Contribution \$ _____
For Parking	
\$270.00 _____ Maximum Monthly Contribution	Per Pay Period Contribution \$ _____
For Transit	

**I Understand That:**

- (1) My employer will be deducting the allocations stated above from pay check for the purposes of funding my Flexible Spending Account plan(s).
- (2) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for each new plan year.
- (3) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status, marriage, divorce, death of spouse or child, birth or adoption of child, termination or commencement of employment of a spouse, or such other qualifying events allowed by the Internal Revenue Code that will permit a change or revocation of an election.
- (4) London Health Administrators may reduce, cancel, or otherwise modify this agreement in the event they believe it is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- (5) This agreement is subject to the terms of the Company's Flexible Spending Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).
- (6) By signing this form, I agree to the terms and procedures listed herein.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Plan Administrator:** London Health Administrators