Advanced Benefit Strategies
Your Flexible Benefits Specialists

Section 125 & 132
HCR, DCR,TRN & PRK - Enrollment IRS Section 125 &132

Health Care (HCR) Dependent Care (DCR) Transit/Commuting (TRN) & Qualified Parking (PRK)

I. Employee Enrollment

Employer Name:					
Your Name (last, first, middle)	Your Employee ID Number		Date of Birth	Gender	Marital Status
Mailing Address	City	State	Zip	( ) Day Time Phone Number	
email address:					

II. List Dependents *(If any)*

Spouse's name (last, first, middle)	Date of Birth	Dependent's name (last, first, middle)	Date of Birth
Dependent's name (last, first, middle)	Date of Birth	Dependent's name (last, first, middle)	Date of Birth

III. Enrollment Election *(check which plans you want and complete information)*

☐ Yes, I elect to participate in a Dependent Care Reimbursement (DCR) Account: Annual Election: $___________________
☐ No, I do not elect to participate.

Enter the name and Tax ID # or SS# of your Dependent Care provider on IRS form 2441 when filing your annual Federal tax.

☐ Yes, I elect to participate in a Health Care Reimbursement (HCR) Account: Annual Election: $_________________
☐ No, I do not want to participate.

☐ Yes, I elect to participate in a Transit / Commuting (TRN) Account: Monthly Election: $_________________
☐ No, I do not want to participate.

☐ Yes, I elect to participate in a Qualified Parking (PRK) Account: Monthly Election: $_________________
☐ No, I do not want to participate.

I certify that all the information on this form is correct. I understand that: Any amount remaining in my Health Care Reimbursement (HCR) and/or Dependent Care Reimbursement (DCR), accounts at year end will be forfeited in accordance with current plan provisions and the IRS tax laws; and that all plan deductions are in effect for the full plan year and cannot be changed or stopped unless I experience a change in family or employment status.

Employee's Signature: ____ Date: ______________________

Return completed Enrollment Form to your Benefit Department

Employer Use Only Required	Date of Hire: / /	Effective Date: / /	# of Paychecks remaining this Plan Year:
Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly			Pay Date of First Deduction: / /
Health Care Deduction Per Pay Period: $	Dependent Care Deduction Per Pay Period: $	Transit/Commuting Per Pay Period: $	Qualified Parking Per Pay Period: $
☐ Mid-Year Status Change (See plan document for list of qualifying events) Explain:			
Note to employer Representative: Please retain the original copy of this form for you records and provide a photocopy to ABS.			

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