Enrollment Form

Effective Date: _____

Richmond Fitness Dependent Care Reimbursement Plan

Employee Information

Name: _____
(Last, First, Middle Initial)

Social Security #: _____ - _____ - _____

Home Address: _____
(Street Address)

Date of Hire: _____/_____/_____

_____
(City, State ZIP Code)

Marital Status (check one): [ ] Single [ ] Married

Dependents to be Covered

Last Name, First Name	Sex	Birth Date	Social Security Number	Relationship to Employee
_____	_____	___/___/_____	_____ - ___ - _____	_____
_____	_____	___/___/_____	_____ - ___ - _____	_____
_____	_____	___/___/_____	_____ - ___ - _____	_____
_____	_____	___/___/_____	_____ - ___ - _____	_____

Standard Payroll Schedule

The following is a list of pay days that will occur during the Plan Year (From 01/01/2022 to 12/31/2022). You can use it to count the number of pay periods that will occur while you are on the plan and calculate your annual reduction amount.

1/10/2022, 1/25/2022, 2/10/2022, 2/25/2022, 3/10/2022, 3/25/2022, 4/10/2022, 4/25/2022, 5/10/2022, 5/25/2022, 6/10/2022, 6/25/2022, 7/10/2022, 7/25/2022, 8/10/2022, 8/25/2022, 9/10/2022, 9/25/2022, 10/10/2022, 10/25/2022, 11/10/2022, 11/25/2022, 12/10/2022, 12/25/2022

Annual Reduction

You are reducing your annual compensation to pay for eligible dependent care expenses with pre-tax dollars. This is a voluntary plan and the amount you designate as your Annual Salary Reduction should be conservative. Remember, if you do not utilize the funds, you lose them. The maximum Annual Salary Reduction Amount is $5,000.00.

Entry Date into the Plan (First Payroll Reduction)	Number of Remaining Pay Periods	Desired Reduction Per Pay Period	Annual Reduction Amount (Pay Periods X Desired Reduction)
___/___/_____	_____	$_____	$_____

Salary Reduction Agreement

I have read and understand the Explanation of Benefits detailing the Richmond Fitness Dependent Care Reimbursement Plan. With this authorization, I am directing Richmond Fitness to reduce my annual compensation by the Annual Reduction Amount shown and reimburse me upon submitting eligible dependent care receipts. By reducing my annual compensation, I am essentially paying for eligible dependent care expenses with pre-tax dollars. I understand that this annual reduction is irrevocable and cannot be changed unless a "Change in Life Status" is experienced.

_____ _____
(Signature) (Date)