FSA Dependent Application Form

Please read instructions and requirements on bottom

_____
Employer

_____ _____-_____-_____
Name: Last, First, MI Social Security Number

_____ _____
Street Address City, State, ZIP

DEPENDENT 1 Debit Card ( ) Yes ( ) No

_____ _____-_____-_____
Full Name Social Security Number

_____ _____ Disabled ( ) Yes ( ) No
Relationship to Employee DOB

**Please explain in detail any circumstances needing special attention such as court ordered arrangements, disabled relatives other than children, etc. Please attach all required documentation.

_____

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_____

DEPENDENT 2 Debit Card ( ) Yes ( ) No

_____ _____-_____-_____
Full Name Social Security Number

_____ _____ Disabled ( ) Yes ( ) No
Relationship to Employee DOB

**Please explain in detail any circumstances needing special attention such as court ordered arrangements, disabled relatives other than children, etc. Please attach all required documentation.

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DEPENDENT 3

Debit Card ( ) Yes ( ) No

_____ _____-_____-_____

Full Name Social Security Number

_____ _____ Disabled ( ) Yes ( ) No

Relationship to Employee DOB

**Please explain in detail any circumstances needing special attention such as court ordered arrangements, disabled relatives other than children, etc. Please attach all required documentation.

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DEPENDENT 4

Debit Card ( ) Yes ( ) No

_____ _____-_____-_____

Full Name Social Security Number

_____ _____ Disabled ( ) Yes ( ) No

Relationship to Employee DOB

**Please explain in detail any circumstances needing special attention such as court ordered arrangements, disabled relatives other than children, etc. Please attach all required documentation.

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DEPENDENT 5

Debit Card ( ) Yes ( ) No

_____ _____-_____-_____

Full Name Social Security Number

_____ _____ Disabled ( ) Yes ( ) No

Relationship to Employee DOB

**Please explain in detail any circumstances needing special attention such as court ordered arrangements, disabled relatives other than children, etc. Please attach all required documentation.

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I understand that a Dependent will not be added unless the Plan Administrator determines that the change is consistent with the Plan Administrator's guidelines, the Plan document and applicable by law. I certify that the information provided above is true and complete.

_____ _____

Employee Signature Date

How to Submit your completed application and documentation to Bouchey & Clarke Benefits, Inc.

1. **Fax** completed Form along with documentation to: 518-874-5002.
   Please use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to BCBI.
2. **Scan and Email** to sdawes@bouchey.com.
3. **Mail** completed form and documentation to:
   Bouchey & Clarke Benefits, Inc.
   ATTN: Sue Dawes
   PO Box 1616
   Troy, NY 12181-1616

For Customer Service please call: 518-720-8888 ext. 122
Or Email: sdawes@bouchey.com

Bouchey & Clarke Benefits, Inc. looks forward to serving as your FSA Administrator.

bouchey &clarke BENEFITS, INC.