

FSA Dependent Application Form

Please read instructions and requirements on bottom

HFM BOCES
Employer

Name: Last, First, MI

_____-_____-_____
Social Security Number

Street Address

City, State, ZIP

DEPENDENT 1

Debit Card () Yes () No

Full Name

_____-_____-_____
Social Security Number

Relationship to Employee

DOB

Disabled () Yes () No

****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.**

DEPENDENT 2

Debit Card () Yes () No

Full Name

_____-_____-_____
Social Security Number

Relationship to Employee

DOB

Disabled () Yes () No

****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.**

DEPENDENT 3

Debit Card () Yes () No

Full Name

_____-_____-_____
Social Security Number

Relationship to Employee

DOB

Disabled () Yes () No

****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.**

DEPENDENT 4

Debit Card () Yes () No

Full Name _____

Social Security Number _____

Relationship to Employee _____

DOB _____

Disabled () Yes () No

****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.**

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 mamurphy@bouchey.com.
3. **Mail** completed form and documentation to:
Bouchey & Clarke Benefits, Inc.
ATTN: Mary Anne Murphy
PO Box 1616
Troy, NY 12181-1616

**For Customer Service please call: 518-720-8888
Or Email: mamurphy@bouchey.com**

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