RICHLAND COUNTY
FLEXIBLE SPENDING ACCOUNT

Department Name:_____
Employee Number:_____
Employee Name: _____
Employee SSN: _____
Employee DOB: _____

EMPLOYEE

ADDRESS:_____
City:_____ State:_____ Zip:_____ Phone:_____

FLEXIBLE SPENDING ACCOUNT	**PER PAY**	**ANNUAL AMOUNT**
A. Unreimbursed Medical Expenses	_____ X 24 Pays	_____ ($2,700.00 max)
B. Dependent Day Care	_____ X 24 Pays	_____ ($5,000.00 max)

SIGNATURE_____ Date _____