

**FLEXIBLE SPENDING ACCOUNT
ENROLLMENT FORM**

Plan Year: _____



M.A. Services
PO Box 587
Pittsford, NY 14534
800.836.8100
FAX: 585.248.2488

EMPLOYEE INFORMATION (Please Print)

Employer: _____

Employee Name: _____ Employee SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: (All communications will be sent to this address unless otherwise elected below.) _____ Home Telephone: _____ Work Telephone: _____

Month	Birth Date: Day	Year	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Month	Date Employed: Day	Year
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DEPENDENTS (Please Print)

Name	Relationship	Gender	Birth Date	Social Security #
	spouse			

- I AUTHORIZE MY SPOUSE OR THE FOLLOWING REPRESENTATIVE TO DISCUSS MY ACCOUNT:
NAME: _____ RELATIONSHIP: _____ SSN: _____
- I elect NOT to receive all communications regarding my Flexible Spending Account electronically and would like all communications sent to the address provided above.

IMPORTANT:
By enrolling the Flexible Benefits Plan I understand that:

- I will be paid from the Flexible Spending Account(s) upon submission of properly prepared claim forms.
- I may not change my election during the Plan Year unless I experience a change in status.
- I may not transfer money between options.
- I will forfeit any balance remaining after year end.

EMPLOYEE ELECTIONS

Benefit Election Options	Participation		Salary Reduction Amount		
	YES	NO		No. of pay periods during the Plan Year	
Unreimbursed Medical, Dental, Vision Expenses Maximum of \$2,700 per Plan Year	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per pay period		\$ _____ per Plan Year
Dependent Care Expenses Maximum of \$5,000 per Plan Year (\$2,500 if married filing separately)	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per pay period		\$ _____ per Plan Year
Individual Disability (Payroll Deducted ONLY) Maximum enrollment equals cost of coverage	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per pay period		\$ _____ per Plan Year
COBRA Health Insurance (ER Sponsored ONLY) Maximum enrollment equals cost of coverage	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ per pay period		\$ _____ per Plan Year

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and that the children listed above either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any remaining dollars in my account(s) not used for eligible expenses incurred in the elected category, during the Plan Year, will be FORFEITED in accordance with current Plan provisions and tax laws. I understand that the Flexible Compensation reduction(s) will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status or terminate employment. (See printed SPD). **I ALSO UNDERSTAND THAT THE FLEXIBLE COMPENSATION REDUCTIONS MAY HAVE SOME EFFECT ON MY SOCIAL SECURITY RECEIPTS.** To compensate for this I have been offered a supplemental company retirement or deferred compensation plan.

Employee Signature: _____ Date: _____