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:
Birth Date: Month / Day / Year	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married	Employment Status: ☐ Full-time ☐ Part-time		Date Employed: Month / Day / Year

DEPENDENTS (Please Print)

Name	Relationship	Gender	Birth Date
	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		
Unreimbursed Medical, Dental, Vision Expenses Maximum of $2,850 per Plan Year	YES ☐ NO ☐	$__________ per pay period	No. of pay periods during the Plan Year	$__________ per Plan Year
Dependent Care Expenses Maximum of $5,000 per Plan Year ($2,500 if married filing separately)	YES ☐ NO ☐	$__________ per pay period	No. of pay periods during the Plan Year	$__________ per Plan Year
Individual Disability (Payroll Deducted ONLY) Maximum enrollment equals cost of coverage	YES ☐ NO ☐	$__________ per pay period	No. of pay periods during the Plan Year	$__________ per Plan Year
COBRA Health Insurance (Employer Sponsored ONLY) Maximum enrollment equals cost of coverage	YES ☐ NO ☐	$__________ per pay period	No. of pay periods during the Plan Year	$__________ 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: ______________