Please return this form to your Employer - Mt. Blue RSD #9

Enrollment Form: Flexible Spending Account(s)

Plan Start Date – Plan End Date

GENERAL INFORMATION:

Employee Name: ______________________________

Mailing Address: ______________________________

City: ____________________ State: ____________ Zip: ______________

E-mail Address: ______________________________

Last 4 Digits of SSN: ____________ Date of Birth (MM/DD/YYYY): ______________

Date of Hire (MM/DD/YYYY): ______________________________

FLEXIBLE SPENDING ACCOUNTS:

I elect to participate in the Flexible Spending Accounts and employer-sponsored benefit coverage.
I elect to participate in the Flexible Spending Accounts only.
I elect to participate in the employer-sponsored benefit coverage only.
I do not wish to participate in the Flexible Spending Accounts or employer-sponsored benefit coverage.

	Per Pay Period		# Pay Periods		Annual Election
Health Care FSA - $2,750 Max	________	x	________	=	$ ____________
Dependent Care FSA - $5,000 Max (Day care expenses incurred during employment hours)	________	x	________	=	$ ____________

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

______________________________ ______________

Employee Signature Date

WageWorks is the administrator of your Plan.
Please return this form to your Employer.