ENROLLMENT FORM – FLEXIBLE SPENDING ACCOUNTS

OZAUKEE COUNTY- January 1, 2019 – December 31, 2019

GENERAL INFORMATION:

SSN:	**Employee Name:**	
Mailing Address:		
City:	State:	Zip:
Date of Birth:	Location (if applicable):	
Date of Hire:	Email Address:	

INSURANCE PREMIUMS:

If this plan option is offered by my Employer, I understand that deductions will be withheld from my paycheck for eligible employer-sponsored insurance premiums on a pretax (before tax) basis.

FLEXIBLE SPENDING ACCOUNTS:

☐ I hereby elect to participate in the Flexible Spending Account(s)

	Per Pay Period	# Pay Periods	Annual Election
Health Care Reimbursement **(Maximum per year: $2,650.00)**	$_____	x 26 =	$ 0
Dependent Care Reimbursement **(Maximum per year: $5,000.00)** (Day care expenses incurred during employment hours)	$_____	x 26 =	$ 0

Effective date of coverage: January 1, 2019

The first payroll deduction will be on January 11, 2019 (bi-weekly). January 25, 2019 (monthly)

My pay schedule is: ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly

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.

Date _____ Employee Signature _____

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