

- New Enrollment
- Change in Family Status

Personnel ID#: _____

**MONROE COUNTY
CAFETERIA/FLEXIBLE BENEFITS PROGRAM
2008 ENROLLMENT FORM**

EMPLOYEE INFORMATION (Please Print)																				
Employee Name:			Employee Social Security Number: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>																	
Address:		City:		State:		Zip code:														
Email Address:			Home Telephone:		Work Telephone:															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: center;">Birth Date</th> <th style="text-align: center;">Gender:</th> <th style="text-align: center;">Marital Status:</th> <th style="text-align: center;">Effective Date:</th> <th style="text-align: center;">Month/Day/Year</th> <th style="text-align: center;">Human Resources Approval:</th> </tr> <tr> <td style="font-size: 8px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; font-size: 8px;">Month</td> <td style="width: 20px; height: 20px; font-size: 8px;">Day</td> <td style="width: 20px; height: 20px; font-size: 8px;">Year</td> </tr> </table> </td> <td style="font-size: 8px;"> <input type="checkbox"/> Male <input type="checkbox"/> Female </td> <td style="font-size: 8px;"> <input type="checkbox"/> Single <input type="checkbox"/> Married </td> <td style="font-size: 8px;"> PAYROLL USE ONLY </td> <td style="font-size: 8px;"> ___ / ___ / ___ </td> <td style="width: 100px;"></td> </tr> </table>	Birth Date	Gender:	Marital Status:	Effective Date:	Month/Day/Year	Human Resources Approval:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; font-size: 8px;">Month</td> <td style="width: 20px; height: 20px; font-size: 8px;">Day</td> <td style="width: 20px; height: 20px; font-size: 8px;">Year</td> </tr> </table>	Month	Day	Year	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	PAYROLL USE ONLY	___ / ___ / ___						
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Month	Day	Year																		

DEPENDENTS (Please Print)					
	Name	Medical	Dependent Care	Birth Date	Social Security #
Spouse		<input type="checkbox"/>			
Dependent		<input type="checkbox"/>	<input type="checkbox"/>		
Dependent		<input type="checkbox"/>	<input type="checkbox"/>		
Dependent		<input type="checkbox"/>	<input type="checkbox"/>		
Dependent		<input type="checkbox"/>	<input type="checkbox"/>		

IMPORTANT:

By enrolling in the Cafeteria/Flexible Benefits Program I understand that:

- I will be paid from the reallocation account(s) upon submission of properly prepared claim forms.
- I may not change my election during the Plan Year except for a change in family status.
- I may not transfer money between options (Health and Dependent Care).
- I will forfeit any balance remaining 90 days after year end.
- I may submit claims up to 30 days from the date of separation for services incurred prior to the separation date.
- My flexible benefits claim will be paid via direct deposit into my checking or savings account. (Attach Direct Deposit Authorization Form)

I elect to have my out-of-pocket Monroe County Dental Expenses automatically paid through the Flexible Spending Account.

EMPLOYEE ELECTIONS							
Benefit Election Options	Participation		Salary Reduction Amount				
Medical/Dental/Vision Account Maximum of \$3,000 per plan year.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	\$ _____ PLAN YEAR	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: 8px;">No. of pay periods during the Plan Year.</td> <td align="center" style="font-size: 24px; border: 1px solid black;">26</td> </tr> </table>	No. of pay periods during the Plan Year.	26	DO NOT WRITE IN THIS BOX \$ _____ per pay period
No. of pay periods during the Plan Year.	26						
Dependent Care Account Maximum of \$5,000 per plan year. (\$2,500 if married filing separately) YOU MUST COMPLETE AND SUBMIT FEDERAL FORM W-10 FOR EACH CHILD CARE PROVIDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	\$ _____ PLAN YEAR	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="font-size: 8px;">No. of pay periods during the Plan Year.</td> <td align="center" style="font-size: 24px; border: 1px solid black;">26</td> </tr> </table>	No. of pay periods during the Plan Year.	26	\$ _____ per pay period
No. of pay periods during the Plan Year.	26						

NOTE: Amounts allocated to Health Care and/or Dependent Care are pre-tax expenditures. New employees; if you enroll after the beginning of the Plan Year, pay period amounts will be prorated according to the length of time remaining in the plan year. If an annual amount is not evenly divisible by the number of pay periods, the pay period amount will be rounded downward.

Employee Signature: _____

Date: _____

Please return this enrollment by December 3, 2007 to: **Human Resources, Room 210
County Office Building
39 West Main Street
Rochester, NY 14614-1471**