

- New Enrollment  
 Change in Family Status

## MONROE COUNTY FLEXIBLE BENEFITS PROGRAM 2010 ENROLLMENT FORM

EMPLOYEE INFORMATION (Please Print)					
Employee Name:			SAP ID Number:		
Address:		City:		State:	Zipcode:
Email Address:			Home Telephone:		Work Telephone:
Birth Date	Gender:	Marital Status:	Effective Date: Month/Day/Year		Human Resources Approval:
Month	Day	Year	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	PAYROLL USE ONLY    ___ / ___ / ___

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:

- ◇ Reimbursement from my Flexible Benefit Account will automatically be direct deposited into an account I have chosen. (Attach a Direct Deposit Authorization Form).
- ◇ 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 termination for services incurred prior to the separation date.

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

Benefit Election Options	Participation	Pay Periods	Salary Reduction Amount
<b>Medical/Dental/Vision Account</b> Maximum of \$3,000 per plan year.	YES    NO <input type="checkbox"/> <input type="checkbox"/>	26	\$ _____ PLAN YEAR
<b>Dependent Care Account</b> Maximum of \$5,000 per plan year. (\$2,500 if married filing separately)	YES    NO <input type="checkbox"/> <input type="checkbox"/>	26	\$ _____ PLAN YEAR

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 8, 2009 to: Human Resources, Room 210  
 County Office Building  
 39 West Main Street  
 Rochester, NY 14614