

- New Enrollment
- Change in Enrollment

## MONROE COUNTY 2012 FLEXIBLE BENEFITS PROGRAM ENROLLMENT FORM

<b>Birth Date:</b>	<b>Gender:</b>	<b>Marital Status:</b>	<b>Date of Hire:</b>	<b>Effective Date:</b>
Mo Day Year	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	Mo Day Year	Mo Day Year
<b>Name:</b>			<b>Payroll Use Only</b>	
<b>Address:</b>			<b>Social Security #:</b>	
<b>City:</b>			<b>Email Address:</b>	
<b>State:</b>		<b>Zip code:</b>	<b>Work Telephone:</b>	<b>SAP ID:</b>

DEPENDENTS	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"/>		

Benefit Election Options	Participation	Pay Periods	Salary Reduction Amt.
<b>Medical/Dental/Vision/Rx</b> \$3,000 maximum per plan year I have completed 12 full months of service in order to be eligible to participate in this Plan.	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	<b>26</b> \$ _____ <b>PLAN YEAR</b>
<b>Dependent Care Account*</b> \$5,000 maximum per plan year (\$2,500 if married filing separately) The Benny™ Prepaid Benefits Card cannot be used for Dependent Care. * This plan is for eligible dependent children under age 13	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	<b>26</b> \$ _____ <b>PLAN YEAR</b>

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

- ◇ Reimbursement from my Flexible Benefit Account will automatically be direct deposited and I hereby authorize Health Economics Group, Inc. (HEG) to originate electronic credit transactions to my bank (or credit union or savings & loan) account indicated below and to credit the same to such account. If necessary, HEG may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until HEG has received written notification from me of its termination in such time as to afford HEG and my bank a reasonable opportunity to act on it.
- ◇ Amounts allocated to Health Care and/or Dependent Care are pre-tax expenditures. 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).
- ◇ Dependent Care expenses will be reimbursed up to the balance funded through payroll deductions.
- ◇ My Monroe County unreimbursed Dental Expenses will be automatically paid through my Flexible Benefits Account. The Benny™ Prepaid Benefits Card may not be used for Dental Expenses.
- ◇ I may submit claims up to 30 days from the date of termination for services incurred prior to the separation date. I will forfeit any balance remaining 90 days after year end.
- ◇ If an annual amount is not evenly divisible by the number of pay periods, the pay period amount will be rounded downward.
- ◇ The Benny™ Prepaid Benefits Card is for use with my Flexible Benefits Program, and I agree that I and my dependents (if any) will use the debit card solely for its intended use. I understand that I must submit documentation substantiating any and all of my purchases upon request from Health Economics Group. If this card is misused in any way, I understand that it will be turned off for future use, and it will remain my responsibility to reimburse the plan for all ineligible expenses. Further, I agree to read and to abide by all terms described in detail with materials received with my Benny™. Should I request a replacement debit card, I am aware that there is a \$10 fee that will automatically be deducted from my plan balance.

**New employees; if you enroll after the beginning of the Plan Year, pay period amounts will be prorated by the length of time remaining in the plan year.**

Direct Deposit Bank Information (Mandatory) <i>Must include voided check</i>	
<b>Bank Name:</b>	<b>Account Number:</b>
<b>Account Type:</b> Checking <input type="checkbox"/> Savings <input type="checkbox"/>	<b>Routing Number:</b>

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please return this enrollment by Friday, November 4<sup>th</sup> to: Human Resources, Room 210  
County Office Building  
39 West Main Street  
Rochester, NY 14614**