

New Enrollment
 Change in Family Status
 Personnel ID No. _____

MONROE COUNTY CAFETERIA/FLEXIBLE BENEFITS PROGRAM 2009 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: 10%;"></td> </tr> </table>												
Address:		City:		State:		Zip code:									
Email Address:			Home Telephone:		Work Telephone:										
Birth Date <small>Month Day Year</small>		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Effective Date: Month/Day/Year PAYROLL USE ONLY ___ / ___ / ___		Human Resources Approval:									

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 termination for services incurred prior to the termination date.
- ◇ My flexible benefits claim will be paid via direct deposit into my checking or savings account (Attach direct deposit 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	<small>No. of pay periods during the Plan Year.</small> <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="text-align: center; font-size: 1.2em;">27</td> </tr> </table>	27
27					
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	<small>No. of pay periods during the Plan Year.</small> <table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="text-align: center; font-size: 1.2em;">27</td> </tr> </table>	27
27					
			DO NOT WRITE IN THIS BOX \$ _____ per pay period		

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