Flexible Spending Account / Cafeteria Plan Enrollment / Change Form

Employer Name: **Wayne County**

Last Name: ______________ First Name ______________ M.I. _____ ☐ Male ☐ Female

Email Address ______________ Social Security Number (must be provided) ______________

Street Address ______________ City ______________ State ________ Zip Code __________

Home Phone Number ______________ Date of Birth ______________ Date of Hire ______________

Division of Company ______________ ☐ Single ☐ Family

Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other ______________

Date of first payroll withhold: Month ______________ Day ______________ Year ______________

Spouse Name (First, M.I., Last)	Date of Birth	Spouse Social Security Number:
Dependent Name (First, M.I., Last)	Date of Birth / Gender	Dependent Social Security Number:
Dependent Name (First, M.I., Last)	Date of Birth / Gender	Dependent Social Security Number:

Plan Year Dates: From __07__/__01__/__2018__ to __06__/__30__/__2019__

Account Type (Note: Not all accounts may Apply to your company)	**"Plan Year" Election Amount**	**New/Change?** (Changes must accompany change Report from employer)
FSA - Medical Expense Reimbursement (Ex: Doctor co-payments, Prescriptions, Vision, Dental Expenses) **MAX Election: $2,550**	$________ Plan Year = $________ Per Pay	☐ New ☐ Change
Dependent Care Assistance (Ex: Child Day Care) (*See Note Below) **MAX Election: $5,000**	$ ________ Plan Year = $ ________ Per Pay	☐ New ☐ Change

Cafeteria Plan Election Statement:

☐ I elect to participate in my employer's Flexible Spending Account Plan and agree to be bound by the terms of my employers plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security Benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year noted above will be forfeited.

☐ I **do not** wish to have my FSA Election Amount Dollars deducted from my pay on a pre-tax basis.

☐ I **do not** wish to participate in the FSA this year. I understand I will not be able to participate until the next plan year.

***Year-End Tax Credit may produce greater savings than paying for DCAP FSA benefits with pre-tax salary reduction contributions. (Consult your Tax Advisor if unsure.)**

Please note: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

*AUTHORIZATION : I hereby elect the benefits indicated above. I have read and understood the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used fro eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT ______________________________ Date ______________

Any Questions please call AdminUSA, Inc. @ 252.993.7248 Or Email Heather Turner: HTurner@adminusa.us