MERITAIN HEALTH
An Aetna Company

Saint Mary's College

FSA Enrollment Form

EMPLOYEE INFORMATION			BENEFIT ADMINISTRATOR SECTION	
LAST NAME	FIRST NAME	MI	PLAN YEAR **1/1/2015 - 12/31/2015**	GROUP # **0198**
EMPLOYEE SOCIAL SECURITY NUMBER	SEX ❑ M ❑ F	DATE OF BIRTH	EFFECTIVE DATE	DIVISION #
HOME ADDRESS		EMAIL ADDRESS	DATE OF HIRE	
CITY	STATE	ZIP CODE	PAY CYCLE ❑ MONTHLY – 10 PAYS ❑ MONTHLY – 12 PAYS ❑ BI-WEEKLY – 18 PAYS ❑ BI-WEEKLY – 22 PAYS ❑ BI-WEEKLY – 24 PAYS ❑ BI-WEEKLY – 26 PAYS ❑ OTHER: _____	
HOME TELEPHONE	WORK TELEPHONE	**I GIVE THE FSA TEAM PERMISSION TO RELEASE INFORMATION ABOUT MY FSA TO MY SPOUSE. ❑ YES ❑ NO**		

Please check all that apply:

❑ HEALTH CARE ACCOUNT

I would like to contribute $_____ per pay period ($_____ annually) to my Healthcare Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $2,550 per plan year.

❑ DEPENDENT CARE ACCOUNT

I would like to contribute $_____ per pay period ($_____ annually) to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $5,000 per family or $2,500 per individual (or spouse when married and filing separate tax returns)

ELIGIBLE DEPENDENTS:

Dependent's Name (Last, First, MI)	Sex	Relationship	Birth Date	Social Security Number
		Spouse		
		Child		
		Child		
		Child		

❑ DEBIT CARD

EMPLOYEE SIGNATURE REQUIRED

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

EMPLOYEE SIGNATURE	DATE
	

HUMAN RESOURCES USE ONLY:

Date Received _____ Date Submitted _____

PMI Deduction _____ Enrollment Confirmation _____

PDI Deduction _____ Confirmation Info _____