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Nye County Flexible Benefits Enrollment Form – Plan Year 2016 - 2017 Healthcare and Dependent Care FSA

This form is to elect to participate in the Flexible Spending Account(s) **Plan Year 7/1/2016 - 6/30/2017.**

Employees are required to re-enroll each year for participation in a FSA. If you do not wish to participate in a Flexible Spending Account in calendar year 2016-2017, you do not need to complete and return this form.

If you currently participate in the FSA program and have a Benny Prepaid MasterCard, keep this card. Your current card will be loaded with your 2016-2017 election amount. A new card WILL NOT be mailed to you.

Employee Last Name

MI.

Employee First Name

Gender (M or F)

Home Address (include Apt. Number if applicable)

City

State

Zip Code

Date of Birth (mmddyy)

Date of Hire (mmddyy)

FSA Effective Date (mmddyy)

Social Security Number

Election Information:

Healthcare Flexible Spending Account (Healthcare FSA)

Annual maximum allowable is: \$ 2,500

I elect to participate \$ _____ for the 2016-2017 plan year.
(Insert the Total Annual Election Amount)

I elect to waive participation

I understand that the amount above will be divided by 24 pay periods for a deduction of \$ _____ per pay check.
(Divide Total Election by 24)

Dependent Care Flexible Spending Account (Dependent Care FSA)

Annual maximum allowable is: \$5,000 (\$2,500 if married, filing separately)

I elect to participate \$ _____ for the 2016-2017 plan year.
(Insert the Total Annual Election Amount)

I elect to waive participation

I understand that the amount above will be divided by 24 pay periods for a deduction of \$ _____ per pay check.
(Divide Total Election by 24)

Authorization:

I have reviewed the terms of my employer's Flexible Benefits Plan. I understand that I may elect coverage under any or all of the above components. I understand that the contributions for the participation that I elect will be deducted from my compensation on a pre-tax basis and the deductions cannot be changed until the next plan year unless there is a change in status. I have read and agree to the terms of participation. I authorize a fee of \$5.50 per month be deducted from my pay for FSA administration.

Employee's Signature

Date