ENROLLMENT APPLICATION

☐ Initial Enrollment ☐ Plan Year Enrollment ☐ Change

(Please Print)

Employee Name: _____ Effective Date: _____

Address: _____ Social Security #: _____

_____

_____

Date of Employment: _____ Number of Dependent Children: _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT

I hereby authorize the Capital Area Health Consortium to reduce my earnings for the plan year by $_____ for deposit into my Dependent Care Reimbursement Account and to make this money available to me for the reimbursement of out-of-pocket dependent care expenses. I agree to have $_____ per pay check deducted beginning pay date_____for a total annual amount of $_____.

I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.

I FULLY UNDERSTAND THAT MY FUTURE SOCIAL SECURITY BENEFITS MAY BE AFFECTED AS A RESULT OF MY PARTICIPATION IN THIS OPTIONAL BENEFIT PLAN.

I UNDERSTAND IT IS MY RESPONSIBILITY TO REQUEST A NEW ENROLLMENT APPLICATION AND MAKE THE NECESSARY ADJUSTMENTS IN THE YEAR I PLAN ON TERMINATION OF EMPLOYMENT ON JUNE 30th (FINAL 6 MONTHS OF SERVICE).

I ACKNOWLEDGE I HAVE BEEN INFORMED OF THE ABOVE.

Signature: _____ Date: _____

NOTE: Salary reduction elections must be made in whole dollar amounts. These elections will be divided by the number of pay periods in the plan year, and be credited to your Account or Accounts on a monthly basis. Your salary reduction is made on a pre-tax basis, in accordance with the IRC Section 125 guidelines.