



BENEFITS ENROLLMENT FORM

For enrollment assistance, please call Customer Care at (877) 933-3539. Have your enrollment form, Client TASC ID, and company name available. Please print this form, sign, and return to your employer for processing.

EMPLOYEE INFORMATION					
Employee Name:		Last Name	First Name		Middle Initial
Social Security Number:		Date of Birth:		Gender:	
Home Address:		Street	City	State	Zip Code
Email Address:			Telephone #:		
EMPLOYER/BENEFITS INFORMATION					
Employer Name:			Date of Hire:		
Plan Effective Date:			Date of 1 st Payroll Deduction:		
Insurance Carrier Name:					
PLAN ELECTIONS					
Plan Type	Annual Election (\$)	Number of Payrolls	Amount per Pay Check (\$)	Employer Contribution (if applicable)	
				Per Month	Per Year
<input type="checkbox"/> Healthcare Flexible Spending Account (FSA):					
<input type="checkbox"/> Dependent Care FSA:					
FOR DEPENDENT COVERAGE:		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, list your spouse and dependent children below:	
		Dependent Children? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last Name	First Name	Social Security Number*	Relationship to Employee	Date of Birth*	Gender
AUTHORIZATION					
<p>I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws.</p> <p>Furthermore, I agree that the IRS regulations state four conditions: (1) any expenses I/we incur must be within the Plan Year; (2) any expenses I/we incur must not be covered by any other sources, such as insurance, (3) I/we must provide proper documentation to receive payment; (4) I/we cannot change or revoke elections during the Plan Year unless there is a specific change in status and my employer allows such changes. Please see Summary Plan Description for details</p>					
Employee Signature				Date	

* Social Security and date of birth for employees and their dependents are required for HRA reporting purposes to the Centers for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Enrollment Forms without this required information will be returned for completion.