GROUP HEALTH
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OFFICIAL SEAL OF NYE COUNTY NEVADA

Nye County Flexible Benefits Enrollment Form – Plan Year 2019 - 2020
Healthcare and Dependent Care FSA

This form is to elect to participate in the Flexible Spending Account(s) **Plan Year 7/1/2019 - 6/30/2020.**

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 2019-2020, you do not need to complete and return this form.

If you currently participate in the FSA program and have a Wex Prepaid MasterCard, keep this card. Your current card will be loaded with your 2018-2020 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) ☐ I elect to waive participation

Annual maximum allowable is: $ 2,700

☐ I elect to participate $____________________________________ for the 2019-2020 plan year.
(Insert the Total Annual Election Amount)

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) ☐ I elect to waive participation

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

☐ I elect to participate $____________________________________ for the 2019-2020 plan year.
(Insert the Total Annual Election Amount)

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