PBS
Professional Benefit Services, Inc.
Affordable administration of employee benefit plans

Effective Date:_____

FLEXIBLE SPENDING ACCOUNT
DEPENDENT CARE ACCOUNT
(CAFETERIA PLAN)
ENROLLMENT FORM

Employer: MARION COUNTY	***Plan Year:***	
Name:	***Marion Co Employee ID:***	***Full SSN:***
Mailing Address:	***Phone Number:***	
City: ***State:*** ***Zip:***	***Email Address:*** *Please provide an email address that is monitored regularly.*	

☐ **NO,** ***I do not wish to enroll in the Flexible Spending Account or Dependent Care Account.***
I understand that I cannot enroll at any other time during the plan year unless I experience a "Change in Status".

☐ **YES,** ***I elect to enroll in the Plan, effective _____, and authorize my employer to reduce my pay by the following amount(s):***

1. FLEXIBLE SPENDING ACCOUNT ANNUAL ELECTION

*****The maximum employee contribution to the health care account (FSA) is capped at a $2,550 annual election. Your specific plan may still have a lower maximum contribution.*

Per Pay Period Amount $_____ X Number of Pay Periods _____	**TOTAL ANNUAL FSA ELECTION**	**$**

2. DEPENDENT DAYCARE ACCOUNT ANNUAL ELECTION

**Please note- Dependent day care expenses include expenses incurred for the care of dependent children under the age of 13 so that you and your spouse can work, look for work or be a full-time student. School tuition may not be reimbursed. For handicapped dependents 13 and over, please contact Professional Benefit Services. The daycare election is capped at $5,000 per household.*

Per Pay Period Amount $_____ X Number of Pay Periods _____	**TOTAL ANNUAL DCA ELECTION**	**$**

3. DEBIT CARD REQUEST

A Benefits MasterCard pays directly from your FSA at the point of service.

☐ **Please order a Benefits MasterCard for my dependent listed below**

*Dependent Last Name:*_____ *First Name:*_____ *ID#(SSN):*_____

4. New Authorization Statement

I authorize and request Professional Benefit Services, Inc. to instruct my financial institution to deposit funds to my account. If necessary, initiate debit adjustments for any transaction credited in error. I also understand I may discontinue this authorization at any time by giving written notice to Professional Benefit Services, Inc.

Bank Routing # _____ **Banking Account #** _____

☐ **Provide voided check with enrollment form, direct deposit can not be setup without.** ☐ Checking Account ☐ Saving Account

☐ **I understand** that the salary reduction I have elected for health expenses are recorded separately from the salary reduction for dependent care costs. If there is money recorded in one account at the end of the year, it is not transferable to meet expenses in the other category.

☐ **I understand** that I cannot suspend, increase or decrease my salary reduction during hte plan year unless I experience a "change in status" as described in federal regulations.

☐ **I understand** that all claims paid must be for date of services incurred during the current plan year as stated in the plan document.

☐ **I understand** that if I have a benefits card, it must only be used for eligible expenses not being reimbursed by any other health plan, and I will save all card transaction information because my account may be audited at any time.

☐ **I understand** that any money remaining in my cafeteria plan account(s) at the end of the year in excess of $500 will be forfeited.

☐ **I understand** that the employer cannot be responsible for any tax liabilities that may subsequently occur as a result of my participation. I have received a written explanation of the cafeteria plan.

Your Signature:	Date:
County Authorization:	Date:

An employee signature and company authorization is required for enrollment to be completed

Return completed form to Marion County Benefits.

This Plan Administered by Professional Benefit Services, Inc.
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Email: cafeteria@profben.com Website: www.profben.com