MEDICAL/FLEXIBLE SPENDING ACCOUNTS
ENROLLMENT FORM

EMPLOYER: County of Monmouth **PLAN YEAR: _____**

- Fill in all blank information.
- Indicate the dollar amount you wish deducted from each paycheck and your annual pledge amount.
- Indicate if your want the mySource debit card **at no cost to you**.
- Sign and date this form. Send this form to your Benefits Representative. Please keep a copy for your records.
- Expenses can be incurred from July 1, of the plan year through September 15, of the plan year and must be submitted to IAA by December 31, of the plan year.

Employee Name: **Social Security No.:** **Employee#**

Address: **City:**

Apartment No. **State:** **Zip:**

Phone No.: Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

REIMBURSEMENT ACCOUNT "BEFORE TAX" ALLOCATIONS

I authorize Monmouth County to deduct the following before-tax amount(s) from my compensation each pay period. The amounts will be deposited into my account(s) maintained by Monmouth County. My account(s) will be used to reimburse me for eligible health care expenses or dependent care expenses I incur during the plan year.

	AMOUNT PER PAY PERIOD (Adjust your annual amounts so that the same amount of money will be deducted each pay period)	ANNUAL AMOUNT
MEDICAL FLEXIBLE ACCOUNT:	$_____	$_____
IAA Benefits Card	_____	

AMOUNT MUST BE IN EVEN DOLLARS

MINIMUM PER PAY PERIOD: $10.00

MAXIMUM PER PAY PERIOD: $112.50

Email address _____

I elect to have any contribution(s) for the above specified coverage deducted from my compensation each period on a pretax basis. I understand that my Social Security benefits may be somewhat reduced since Social Security taxes are not paid on my pre-tax deductions and/or contributions.

AUTHORIZATION AND AGREEMENT

I understand these payroll deductions cannot be adjusted during the Plan Year, unless I experience a change in a family status. I further understand that any unused amounts remaining in my reimbursement account(s) at the end of the Plan Year, or applicable grace period, will be forfeited.

Signature of Employee **Date**