



REIMBURSEMENT ACCOUNT ENROLLMENT FORM

Employer Information (employer use only)

Group Name: Medaille College

Effective Date:

Date of Hire:

First Payroll Deduction Date:

Location/Department (if applicable):

Payroll Deduction Frequency (eg. weekly, monthly, etc.):

Employer Initials:

Date:

FOR NEW ENROLLMENTS/Please check one:

☐ OPEN ENROLLMENT

☐ NEWLY ELIGIBLE/REASON _____

☐ NEW HIRE/DATE OF HIRE ____/____/____

FOR CHANGES*/Please check all that apply:

☐ PLAN CHANGE

☐ ADD DEPENDENT

☐ ADDRESS CHANGE

☐ NAME CHANGE

☐ REMOVE DEPENDENT

☐ TERMINATION (effective date) _____

PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION. For changes complete first & last name only.

APPLICANT'S LAST NAME

FIRST NAME

MI

☐ MALE

☐ FEMALE

SOCIAL SECURITY NUMBER

ADDRESS (NUMBER, STREET, APARTMENT)

DATE OF BIRTH

CITY

STATE

ZIP + 4

HOME: ()

CELL: ()

WORK: ()

E-MAIL:

ANNUAL ELECTIONS

	CONTRIBUTION PER PAY PERIOD		# PAY PERIODS REMAINING IN PLAN YEAR		ANNUAL ELECTION AMOUNT
HEALTH CARE FLEXIBLE SPENDING ACCOUNT	\$	X		=	\$
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	\$	X		=	\$
ADOPTION ASSISTANCE	\$	X		=	\$

DEPENDENT INFORMATION

LAST NAME	FIRST NAME	M.I.	SSN	DATE OF BIRTH	RELATIONSHIP	GENDER
DEPENDENT						<input type="checkbox"/> Male <input type="checkbox"/> Female
DEPENDENT						<input type="checkbox"/> Male <input type="checkbox"/> Female
DEPENDENT						<input type="checkbox"/> Male <input type="checkbox"/> Female
DEPENDENT						<input type="checkbox"/> Male <input type="checkbox"/> Female
DEPENDENT						<input type="checkbox"/> Male <input type="checkbox"/> Female

CERTIFICATION & CONSENT

I certify I will have the above total amount deducted from each of my paychecks. I understand this will lower my gross pay, and consequently, my tax base and my Social Security base. I also understand that I cannot make any changes during the plan unless I experience a change in family status. In addition, I certify that if I am issued a debit card with this benefit, I will only use it for eligible medical and/or dependent care expenses as defined by the IRS under Section 213 and/or section 21 for my spouse, dependents, and myself. I also certify any expense paid using such debit card has not been reimbursed by any other plan covering health benefits, nor will I seek reimbursement under any other plan or deduct such expenses on my income tax return. I understand this certification is reaffirmed each time the card is used and I agree to acquire and retain sufficient documentation for any expense paid with the card, and submit such documentation as substantiation when requested.

AUTHORIZATION: I have read and agree to the authorization above.

Subscriber's Signature

Date

**According to IRS regulations, you may only change your elections at the beginning of each plan year unless you experience a change in your family status. A change of family status may include marriage, divorce, birth, adoption, death or loss of spouse's employment. Changes in the contribution amount must be consistent with the change in your family status.*