



GROUP ENROLLMENT/CHANGE REQUEST

Horizon Blue Cross Blue Shield of New Jersey

Mail to: Horizon BCBSNJ
Attn: Large and Mid-Size Group Enrollment
P.O. Box 10168
Newark, NJ 07101-3168
Email to: Midmajor_enrollment@horizonblue.com
Fax to: (973) 274-2297
HorizonBlue.com

Group Information to be completed by Employer.

Group Name: Cherry Hill Township

Sub Group Number: _____ Date of Hire: ____ / ____ / ____

Reason: _____

A. Type of Activity to be completed by Employer.

Refer to instructions before completing this form. Print clearly.

ADD REMOVE OTHER CHANGE

Effective Date

Reason for Change

<input type="checkbox"/> Subscriber	____ / ____ / ____	_____
<input type="checkbox"/> Spouse	____ / ____ / ____	_____
<input type="checkbox"/> Civil Union Partner (CUP)	____ / ____ / ____	_____
<input type="checkbox"/> Domestic Partner (DP)	____ / ____ / ____	_____
<input type="checkbox"/> Dependent Child	____ / ____ / ____	_____
<input type="checkbox"/> Over-Age Child as a Dependent Under 31 (and complete Coverage Continuation section)	____ / ____ / ____	_____
<input type="checkbox"/> Name Change	____ / ____ / ____	_____
<input type="checkbox"/> Change Plan	____ / ____ / ____	_____
<input type="checkbox"/> Other	____ / ____ / ____	_____
<input type="checkbox"/> Add/Change Office ID Numbers: Primary Care Provider	____ / ____ / ____	_____

COVERAGE CONTINUATION

For Employee Billing: Group

Date of Loss of Coverage

<input type="checkbox"/> Total Disability* <input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29	Date of Qualifying Event
<input type="checkbox"/> For Spouse/Civil Union Partner*/Domestic Partner	Billing: Group	Qualifying Event #**
Date of Loss of Coverage		
<input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29 <input type="checkbox"/> 36	Date of Qualifying Event

*Attach proof of disability

For Dependent or Over-aged Child

<input type="checkbox"/> COBRA/NJSGC	Length of Continuation (in months): <input type="checkbox"/> 18 <input type="checkbox"/> 29 <input type="checkbox"/> 36	Billing: Group
Date of Loss of Coverage	Qualifying Event #**	Date of Qualifying Event
<input type="checkbox"/> Dependent Under 31	Billing: Home	
Date of Loss of Coverage	Qualifying Event #**	Date of Qualifying Event

Home Address: _____

**Qualifying event #s: see list in Instructions.

Employee Information - to be completed by Employee.

ADD REMOVE CONTINUATION OTHER CHANGE

If a name change, indicate prior name: _____

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____ / _____ / _____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ E-Mail Address _____

Employer Name _____ Employment Date _____ / _____ / _____

Employer Address _____ City _____ State _____ Zip Code _____

Hours Worked Per Week _____ Work Phone _____ E-Mail Address _____

Primary Care Provider Name _____ Current Patient Yes No

JCD# _____ Loc Code _____

Other Health Coverage Yes No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

The Employee Copy of this application may be used as a temporary ID card for thirty days from the effective date if authorized by Employer. Coverage must be verified with Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare of New Jersey, Inc. prior to visiting a physician or admission to a hospital.

C. Race/Ethnicity – to be completed by the Employee, at his/her option.

NOTE: Your response is appreciated but NOT required! Choose a category that most closely describes you:

American Indian or Alaskan Native Black, not of Hispanic origin
 Hispanic Asian or Pacific Islander White, not of Hispanic origin

D. Plan Option – to be completed by the Employee. Your selection must be offered by your employerActive Medical/Rx: S F 2 Adults Parent/Child(ren)

Horizon Direct Access Design 8 (No Deductible)
UNION EMPLOYEES ONLY

Horizon Direct Access Design 8 (With Deductible - 2019)
UNION EMPLOYEES ONLY

Horizon Direct Access Design 7 (20/30)
(Union Silver) (Non-Union Gold)

Horizon POS-1 (Union & Non-Union Silver Plan - PCP required)

 Omnia State Defector (w BlueCard)

Horizon State Defector HSA (High Deductible)

Retiree Medical/Rx: Single Family 2 Adults Parent/Child(ren)

Horizon Direct Access Design 8 U65 Retiree (No Deductible)

Horizon Direct Access Design 7 U65 Retiree

Horizon State Defector HSA U65 Retiree

OMNIA State Defector w/BlueCard U65 Retiree

Horizon POS-1 (New NC Silver Plan - PCP required)

E. Other Individuals Covered – to be completed by Employee.

Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof of disability.

1. SPOUSE/CUP/DP ADD REMOVE CONTINUE SPOUSE (COBRA/NJSGC) CONTINUE CU PARTNER (NJSGC) CONTINUE DP (COBRA/NJSGC) OTHER CHANGE

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____ / _____ / _____ Sex _____

Primary Care Provider Name _____ Current Patient Yes No

JCD# _____ Loc Code _____

Other Health Coverage Yes No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

Home or billing address same as Employee? Yes No If No, Complete Section F2**2. Child ADD REMOVE CONTINUATION OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____ / _____ / _____ Sex _____

Primary Care Provider Name _____ Current Patient Yes No

JCD# _____ Loc Code _____

Other Health Coverage Yes No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? Yes No If No, Complete Section G**3. Child ADD REMOVE CONTINUATION OTHER CHANGE**

Last Name, First Name, M.I. _____

Social Security # _____ Date of Birth _____ / _____ / _____ Sex _____

Primary Care Provider Name _____ Current Patient Yes No

NPI# _____ Loc Code _____

Other Health Coverage Yes No, If Yes, Payer Name _____

Policy # _____ Medicare ID #, If any _____

If last name is different from Employee's, please explain: _____

Living with Employee? Yes No If No, Complete Section G

F. Additional Spouse/CUP/DP Information – to be completed by Employee. If not applicable mark as N/A.

1. Employer Name _____ Employer Phone _____
Employer Address _____
City _____ State _____ Zip Code _____
2a. Home Address _____ Apt _____
City _____ State _____ Zip Code _____
2b. Please explain why the address is different: _____

G. Additional Child Information – to be completed by Employee.

Provide information below about children listed in Section E, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Reason: _____
Name _____
Address _____ Apt _____
City _____ State _____ Zip Code _____
Reason: _____

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature: _____ Date: _____ / _____ / _____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make premium payments required from me for the Dependent Under 31 Continuation Election.

Signature: _____ Date: _____ / _____ / _____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer.

Employer Representative: _____ Date: _____ / _____ / _____

Representative's Title: _____

Instructions**Employers**

You must complete the Group Information and sections A and J in order for this application to be processed.

Employees

You must complete sections B through I and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section J in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A, and attach proof of disability.
- Total Disability and COBRA are available continuation options under Vision coverage; Dependent Under 31 continuation is not available under Vision coverage.
- You can obtain the providers' correct names from the appropriate provider directory. You may also obtain each provider's NPI and LOC Code number from the provider directory or at: www.HorizonBlue.com. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events**COBRA and NJSGC**

C1. Termination of job or reduction in hours

C2. Employee enrollment in Medicare (COBRA only)

C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC) if covered under group benefits

C4. Death of employee

C5. Loss of dependent child status under the plan.

C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status (aged out) and otherwise eligible

D2. Re-establish eligibility: residency

D3. Re-establish eligibility: nonresident full-time student

D4. Re-establish eligibility: change in marital status

D5. Re-establish eligibility: change in parental status

D6. Re-establish eligibility: termination of other coverage

Conditions of Enrollment - Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Horizon BCBSNJ¹, or any consumer reporting agency acting on behalf of Horizon BCBSNJ, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Horizon BCBSNJ has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Horizon BCBSNJ will provide coverage in accordance with the terms of the contract for the group plan/policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan/policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

Misrepresentations

Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Notices**General Notice of Special Enrollment Rights**

If you are declining enrollment under your group health plan for yourself and/or your dependents (if your plan includes coverage for dependents) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and those dependents in this group health plan if you or the dependents lose eligibility for that other coverage (or if the other employer or plan provider stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the other employer or plan provider stops contributing toward the other coverage).

In addition, if your plan includes coverage for dependents and you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents under this plan after declining its coverage. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

If you decline coverage under this plan, you may be asked to state in writing whether the declination was due to the existence of other health coverage. If this is so and you don't provide the statement, the above special enrollment rights may not be available to you if you need them.

To request special enrollment or obtain more information about it, contact your benefits department or personnel representative.

Notice on Dependent Under 31 Continuation

Horizon Blue Cross Blue Shield of New Jersey will bill over-age dependents directly and enrollees will remit the premium directly to Horizon BCBSNJ. When Dependent Under 31 Continuation is selected, the home address must be completed under Section "A - Type of Activity" even when it is the same as the employee's address.

Important Note:

- Although the employee must continue eligibility under the dependent's plan for continued coverage of the dependent, in addition to the additional applicable eligibility criteria, coverage for the dependent will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply and will not be combined with the employee's policy. Consequently, covered expenses incurred by the over-age dependent will not contribute to family deductibles and out-of-pocket maximums, nor will family incurred expenses contribute to the over-age dependent's deductibles or out-of-pocket maximums.

Group Subscriber on behalf of itself and its participants hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and Horizon BCBSNJ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Horizon BCBSNJ to use the Blue Cross and Blue Shield Service Marks in the State of New Jersey, and that Horizon BCBSNJ is not contracting as the agent of the Association. Group Subscriber on behalf of itself and its participants further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Horizon BCBSNJ and that no person, entity, or organization other than Horizon BCBSNJ shall be held accountable or liable to Group Subscriber for any of Horizon BCBSNJ's obligations to Group Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Horizon BCBSNJ other than those obligations created under other provisions of this agreement.

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey, Horizon Healthcare of New Jersey, Inc., Horizon Healthcare Dental, Inc., and products and policies may be provided by Horizon Insurance Company, each of which is an independent licensee of the Blue Cross and Blue Shield Association. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies.

[1] Horizon BCBSNJ refers to Horizon Healthcare Services, Inc., doing business as Horizon Blue Cross Blue Shield Of New Jersey or any of its wholly owned subsidiaries including Horizon Insurance Company, Horizon Healthcare Dental, Inc., and Horizon Healthcare of New Jersey, Inc., doing business as Horizon NJ Health.



DENTAL ENROLLMENT FORM
(NON-CONTRACTUAL EMPLOYEES)

Group Number / Plan		
<input type="radio"/> Premier	_____	3202-0001
<input type="radio"/> Premier Buy-Up	_____	3202-0005
<input type="radio"/> Preferred	_____	3202-6001
<input type="radio"/> Preferred Buy-Up	_____	3202-6005

Name of Employer
 Cherry Hill Township
 820 Mercer Street
 Cherry Hill, NJ 08002

Effective Date of Coverage

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last)	(First)	(Middle)	Date of Birth _____/_____/_____	Social Security Number _____-_____-_____
Street Address		City, State, Zip		County
Date of Employment _____/_____/_____	Type of Coverage <input type="radio"/> Single <input type="radio"/> Parent/Child <input type="radio"/> Husband/Wife <input type="radio"/> Parent/Children <input type="radio"/> Family	Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced/Separated	Email Address	
Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		_____-_____-_____	/ /	
Spouse*		_____-_____-_____	/ /	
Dependent		_____-_____-_____	/ /	<input type="radio"/> Yes <input type="radio"/> No
Dependent		_____-_____-_____	/ /	<input type="radio"/> Yes <input type="radio"/> No
Dependent		_____-_____-_____	/ /	<input type="radio"/> Yes <input type="radio"/> No
Dependent		_____-_____-_____	/ /	<input type="radio"/> Yes <input type="radio"/> No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

If choosing Flagship®, you must complete this section

Choice of Dentist		Office Number	For Delta Dental Use Only
1	NOT REQUIRED		
2			
3			

Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorize the release to Flagship Dental Plans of all my treatment information as a DeltaCare® subscriber and the treatment information of my dependent(s). I understand that I may change my primary Plan Participating Dentist by calling or in writing provided that a request for such change is received by Flagship at least thirty (30) days prior to the new contract month. Request received by the tenth (10th) of the month will be effective the first (1st) of the following month.

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Delta Dental Use Only

Entered _____

Operator # _____

Subscriber Signature

Date

BENEFIT/OPTIONAL RATES - CY 2026

Non-Contractual

F/T EMPLOYEES						
MEDICAL					PC	FAM
Effective 01/01/2026 - 12/31/2026		EE	ESP			
HORIZON	Direct Access Design 7 (20/30)	GOLD	1,216.92	2,433.86	2,178.29	3,395.23
HORIZON	POS Design #1 (5/5)	SILVER	1,032.38	2,064.76	1,847.95	2,880.34
HORIZON	OMNIA State Defector	BRONZE	992.11	1,984.21	1,775.86	2,767.96
HORIZON	State Defector HSA (High Deductible)	BRONZE	1,156.07	2,312.13	2,069.36	3,225.43

*High deductible plan includes RX (combined)

F/T EMPLOYEES						
PRESCRIPTION					PC	FAM
Effective 01/01/2026 - 12/31/2026		EE	ESP			
HORIZON	RX \$10/20/35		208.80	417.61	373.77	582.57

F/T EMPLOYEES						
DENTAL					PC2/FAM	
Effective 01/01/2026 - 12/31/2026		EE	ESP/PC1			
Delta Premier		32.36	55.53		102.46	
Delta Premier Buy-Up		37.17	63.79		117.65	
Delta Preferred		29.68	50.26		90.57	
Delta Preferred Buy-Up		34.09	57.73		104.01	

*There is an additional monthly contribution when choosing the medical Gold plan and/or the dental Buy-Up plan. This amount is charged once per month in addition to your bi-weekly premium amount.

F/T EMPLOYEES						
MEDICAL - Monthly Buy-Up Contribution					PC	FAM
Effective 01/01/2026 - 12/31/2026		EE	ESP			
HORIZON	Direct Access Design 7 (20/30)	GOLD	184.54	369.10	330.34	514.89

F/T EMPLOYEES						
DENTAL - Monthly Buy-Up Contribution					PC2/FAM	
Effective 01/01/2026 - 12/31/2026		EE	ESP/PC1			
Delta Premier Buy-Up		4.81	8.26		15.19	
Delta Preferred Buy-Up		4.41	7.47		13.44	



State Health Benefits Program

PERCENTAGE OF PREMIUM CALCULATION CHARTS

For Health Benefit Contributions under P.L. 2011, c. 78

LOCAL GOVERNMENT EMPLOYEES

Annual Retirement Allowance Range	Single	Member/Spouse/Partner or Parent/Child	Family
Less than \$20,000	4.5%		
Less than \$25,000		3.5%	3%
\$20,000 - \$24,999.99	5.5%		
\$25,000 - \$29,999.99	7.5%	4.5%	4%
\$30,000 - \$34,999.99	10%	6%	5%
\$35,000 - \$39,999.99	11%	7%	6%
\$40,000 - \$44,999.99	12%	8%	7%
\$45,000 - \$49,999.99	14%	10%	9%
\$50,000 - \$54,999.99	20%	15%	12%
\$55,000 - \$59,999.99	23%	17%	14%
\$60,000 - \$64,999.99	27%	21%	17%
\$65,000 - \$69,999.99	29%	23%	19%
\$70,000 - \$74,999.99	32%	26%	22%
\$75,000 - \$79,999.99	33%	27%	23%
\$80,000 - \$84,999.99		28%	24%
\$80,000 - \$94,999.99	34%		
\$85,000 - \$89,999.99			26%
\$85,000 - \$99,999.99		30%	
\$90,000 - \$94,999.99			28%
\$95,000 and over	35%		
\$95,000 - \$99,999.99			29%
\$100,000 and over		35%	
\$100,000 - \$109,999.99			32%
\$110,000 and over			35%

Note: Member contribution is a minimum of 1.5% of base salary towards Health Benefits.

PERCENTAGE OF PREMIUM CALCULATION CHART
For Health Benefit Contributions under Chapter 78, P.L. 2011

Use this worksheet and the attached charts to calculate your combined Health Benefit Contribution.

Calculate Premium Percentages		Monthly Amount
1	Use the Benefit Rates Chart and enter the premium amount for your Medical Plan. <i>Please keep in mind that if you select any of the Gold plans, you are responsible for the difference in cost between the Gold and Silver Plan (listed on the Benefit Rates Chart).</i>	
2	Use the Benefit Rates Chart and enter the premium amount for your Prescription Plan.	
3	Use the Benefit Rates Chart and enter the premium amount for your Dental Plan.	
TOTAL MONTHLY:		\$ -
TOTAL YEARLY COST:		\$ -
4	Use the Percentage of Premium Charts for your Level of Coverage to find your Salary Range and Percentage of Premium amount.	
5	Bi-Weekly Contribution Amount: CH 78% * Yearly Premium / 27 pays.	\$ -
Calculate Minimum Required Contribution		
<i>Employees must pay a minimum of 1.5% of Annual Salary</i>		
6	Enter your total Annual Salary.	
7	Multiply your Annual Salary by 1.5%.	1.5%
8	This is your 1.5% Minimum Annual Contribution as a Percentage of Salary.	\$ -
9	This is the minimum monthly amount you are required to contribute: Total Line 8 / 27 pays.	\$ -
Your Health Benefit Contribution		
10	Your Bi-Weekly Contribution is the larger amount of lines 5 and 9. This is Your Bi-weekly Required Contribution .	\$ -

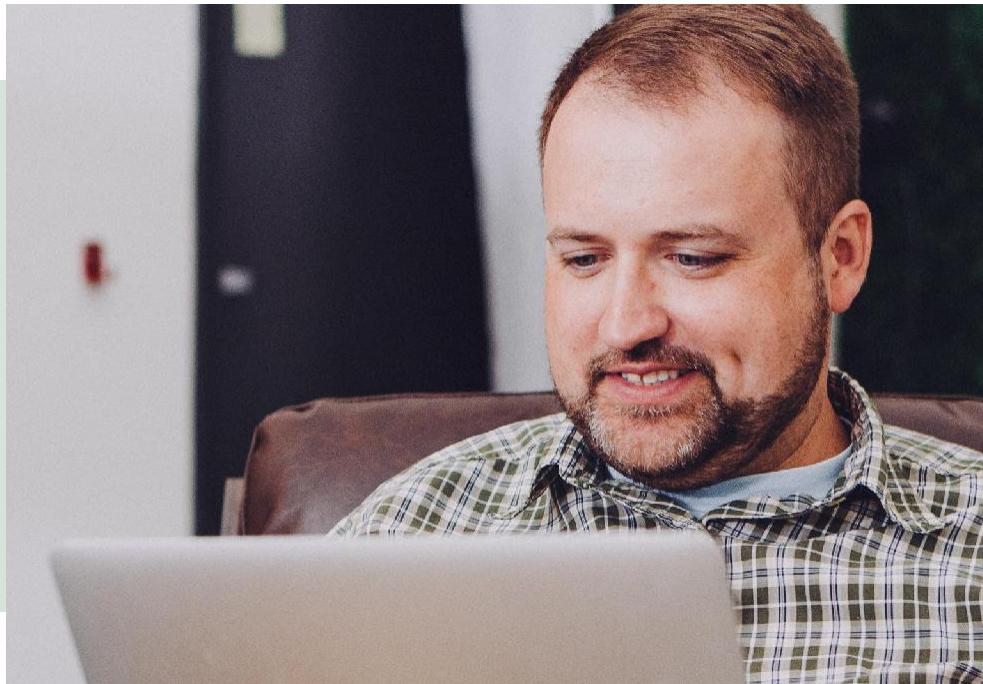
Gold Plan Differential Monthly Contribution		Monthly Amount
1	Use the Benefit Rates Chart and enter the amount for your Gold Medical Plan Differential.	
2	Use the Benefit Rates Chart and enter the premium amount for your Dental Buy-up Plan Differential.	
ADDITIONAL BUY-UP MONTHLY COST:		\$ -

* Bi-Weekly Contribution Changed to 27 Pays for Calendar Year 2026

Flexible Spending Account

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a medical FSA. The annual contribution limit for Cherry Hill Township is \$2,550. We recommend reviewing how much you spend on eligible healthcare expenses every year to determine how much to elect.



Funds on day 1

All of your FSA dollars are available on the very first day of the plan year. For example, if you choose to contribute \$1,200 to your FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all \$1,200 on day 1! You can use your funds for expenses incurred by you, your spouse or eligible dependents.



Use-or-lose

Don't forget to spend your FSA dollars. You will forfeit any money left in your account at the end of the plan year. (Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.)

Changing your FSA election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event. These events include:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status

If you experience a qualifying life event, contact your employer to make changes to your election.

wexTM

Dependent Care Flexible Spending Account

Why should I choose a dependent care FSA?

Dependent Care FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for eligible dependent care expenses each year. The Dependent Care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.*

*Based on a 30% tax bracket.

The IRS sets the maximum dollar amount you can elect and contribute to a Dependent Care FSA. The annual contribution limit is:

Per household - **\$5,000**, Per person (if married or filing separately) - **\$2,500**

Funds available as you contribute. Funds will be available to you as they're deducted from your paycheck and contributed to the plan. This means when payroll is processed and your paycheck is available to you, your Dependent Care FSA contributions will be applied to your account and available for reimbursement.

Use-or-lose. Don't forget to spend your FSA dollars. If you have not used all of your FSA dollars before the end of the plan year, you will forfeit any money left in your account. Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.

Changing your Dependent Care FSA election. In order to make changes to your election after open enrollment, you need to experience a qualifying life event, such as:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status
- Change in daycare providers
- Child turning age 13
- Increase or decrease in the cost of qualifying daycare expenses
- Judgement, decree or order requiring a change in coverage

If you experience a qualifying life event, contact your employer to make changes to your election.

What does it cover?

The list includes, but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before or after-school care
- Disabled dependent and/or spouse care
- Elder care

Can I enroll?

You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.

Flexible Spending Accounts Enrollment Form

Participant Information

Employer Name: _____ **Employer/Location:** _____

Employee Name: _____
 (First Name) _____ (Middle Initial) _____ (Last Name) _____

SSN/EEID: _____ **Date of Birth:** _____

Current Address: _____
 (Street Address) _____

Gender: Male Female

 (Floor or Apt No.)

Marital Status: Single Married Married
 Filing Separately

(City, State Zip) _____

Phone Number: _____
 (Cell Phone Number) _____ (Home Phone Number) _____

Health Care Spending Account:

The Health Care Spending Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

<input type="checkbox"/> Yes, I want to participate <input type="checkbox"/> No, I do not want to participate	\$ _____ + 27 = \$ _____	Plan Year Contribution Max of \$2,550	# Pay Periods in the Plan Year	Pay Period Pre-Tax Contribution
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Dependent Care Spending Account:

The Dependent Care Spending Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you or your spouse (if applicable) to work or attend school on a full-time basis.

<input type="checkbox"/> Yes, I want to participate <input type="checkbox"/> No, I do not want to participate	\$ _____ + 27 = \$ _____	Plan Year Contribution Max of \$5,000 (\$2,500 if filing taxes separate)	# Pay Periods in the Plan Year	Pay Period Pre-Tax Contribution
--	---	---	---------------------------------------	--

I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware that I have a grace period in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a status change and that I may experience future reductions in life, disability and Social Security benefits by participating in this Flexible Spending Plan.

PLEASE SUBMIT THIS COMPLETED FORM TO BENEFITS COORDINATOR. LATE ENROLLMENTS WILL NOT BE ACCEPTED.

Participant Signature _____ **Date** _____