Horizon

Horizon Blue Cross Blue Shield of New Jersey

GROUP ENROLLMENT/CHANGE REQUEST

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 Group Number: 08516R

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

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
☐ Subscriber	_____/_____/_____	_____
☐ Spouse	_____/_____/_____	_____
☐ Civil Union Partner (CUP)	_____/_____/_____	_____
☐ Domestic Partner (DP)	_____/_____/_____	_____
☐ Dependent Child	_____/_____/_____	_____
☐ Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	_____/_____/_____	_____
☐ Name Change	_____/_____/_____	_____
☐ Change Plan	_____/_____/_____	_____
☐ Other	_____/_____/_____	_____
☐ Add/Change Office ID Numbers: Primary Care Provider	_____/_____/_____	_____

COVERAGE CONTINUATION

☐ **For Employee** Billing: Group

Date of Loss of Coverage: _____/_____/_____ Qualifying Event #**: _____ Date of Qualifying Event: _____/_____/_____

☐ Total Disability* ☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 **Attach proof of disability*

☐ **For Spouse/Civil Union Partner*/Domestic Partner** Billing: Group

Date of Loss of Coverage: _____/_____/_____ Qualifying Event #**: _____ Date of Qualifying Event: _____/_____/_____

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36

**Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.*

☐ **For Dependent or Over-aged Child**

☐ COBRA/NJSGC Length of Continuation (in months): ☐ 18 ☐ 29 ☐ 36 Billing: Group

Date of Loss of Coverage: _____/_____/_____ Qualifying Event #**: _____ Date of Qualifying Event: _____/_____/_____

☐ Dependent Under 31 Billing: Home

Date of Loss of Coverage: _____/_____/_____ Qualifying Event #**: _____ Date of Qualifying Even: _____/_____/_____

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 employer

Active 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 BCBSNJ[1], 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.

[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.

DELTA DENTAL

DENTAL ENROLLMENT FORM

(CONTRACTUAL EMPLOYEES)

Group Number / Plan

- ☐ **Premier** _____3202-0001
- ☐ **Preferred** _____3202-6001
- ☐ **PPO Fixed Co-pay** _____ 3202-6007

Name of Employer	**Effective Date of Coverage**
Cherry Hill Township 820 Mercer Street Cherry Hill, NJ 08002	

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**	**Marital Status**	**Email Address**
_____ / _____ / _____	o Single o Parent/Child o Husband/Wife o Parent/Children o Family	o Single o Married o Divorced/Separated	

Enrollment	**First Name - Last Name**	**Social Security Number**	**Date of Birth**	**Full-Time Student**
Subscriber		_____ - _____ - _____	/ /	
Spouse*		_____ - _____ - _____	/ /	
Dependent		_____ - _____ - _____	/ /	o Yes o No
Dependent		_____ - _____ - _____	/ /	o Yes o No
Dependent		_____ - _____ - _____	/ /	o Yes o No
Dependent		_____ - _____ - _____	/ /	o Yes o No

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

I

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

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.

_____ _____

Subscriber Signature **Date**

Delta Dental Use Only

_____

Entered

_____

Operator #

BENEFIT/OPTIONAL RATES - CY 2026

All Unions

F/T EMPLOYEES MEDICAL Effective 01/01/2026 - 12/31/2026			EE	ESP	PC	FAM
HORIZON	Direct Access Design 8 (no Deductible)	***GOLD***	1,247.92	2,495.83	2,233.76	3,481.68
HORIZON	Direct Access Design 8 (Deductible - 2019)	***GOLD***	1,241.34	2,482.68	2,222.00	3,463.35
HORIZON	Direct Access Design 7 (20/30)	***SILVER***	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***	1,186.93	2,373.85	2,124.60	3,311.53

***Optional**

F/T EMPLOYEES PRESCRIPTION Effective 01/01/2026 - 12/31/2026			EE	ESP	PC	FAM
HORIZON	Direct Access Design 8 (no Deductible)	***GOLD***	233.81	467.64	418.54	652.35
HORIZON	Direct Access Design 8 (Deductible - 2019)	***GOLD***	233.81	467.64	418.54	652.35
HORIZON	Direct Access Design 7 (20/30)	***SILVER***	237.80	475.61	425.68	663.48
HORIZON	**POS Design 1 (5/5)**	***SILVER***	**208.80**	**417.61**	**373.77**	**582.57**
HORIZON	OMNIA State Defector	***BRONZE***	236.15	472.32	422.73	658.88

***Optional**

F/T EMPLOYEES DENTAL Effective 01/01/2026 - 12/31/2026		EE	ESP/PC1	PC2/FAM
Delta Premier		32.36	55.53	102.46
Delta Preferred		29.68	50.26	90.57
Delta PPO Fixed Co-Pay Plan		37.97	73.74	123.52

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

F/T EMPLOYEES MEDICAL - Monthly Buy-Up Contribution Effective 01/01/2026 - 12/31/2026			EE	ESP	PC	FAM
HORIZON	Direct Access Design 8 (no Deductible)	***GOLD***	31.00	61.97	55.47	86.45
HORIZON	Direct Access Design 8 (Deductible - 2019)	***GOLD***	24.42	48.82	43.71	68.12

HA-0886-0922

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. *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).*	
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 *Employees must pay a minimum of 1.5% of Annual Salary*		
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**.	**$ -**

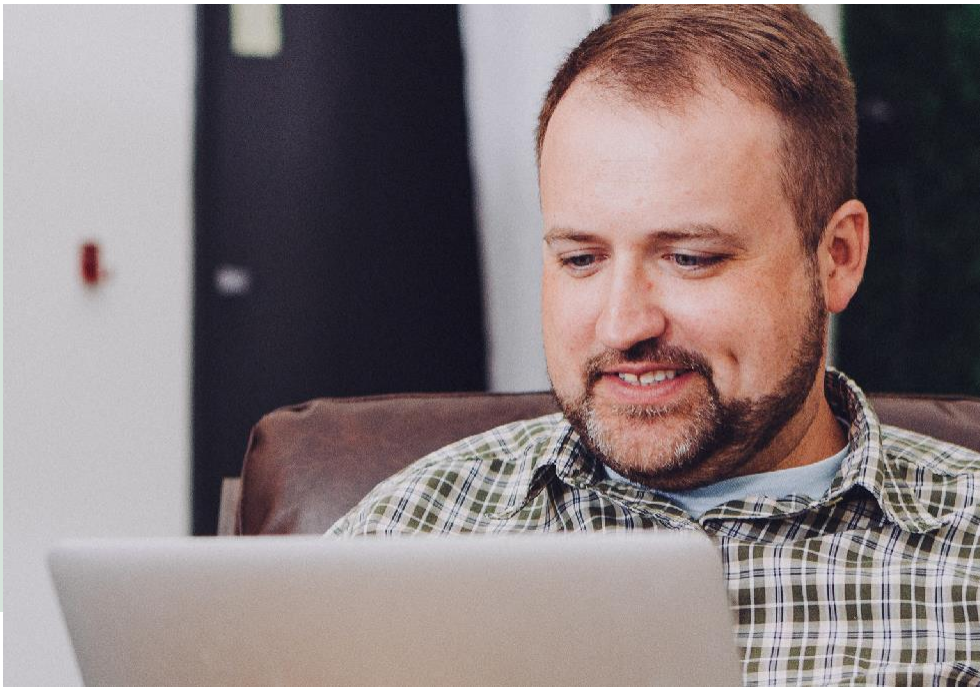
Gold Plan Differential Monthly Contribution		**Monthly Amount**
1	Use the **Benefit Rates Chart** and enter the amount for your Gold Medical Plan Differential.	
2	Use the **Benefit Rates Chart** and enter the premium amount for your Dental Buy-up Plan Differential.	
	ADDITIONAL BUY-UP MONTHLY COST:	**$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

* 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.

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.

Participant Information

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

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

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

Current Address: _____
(Street Address)

_____
(Floor or Apt No.)

_____
(City, State Zip)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately

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.

☐ **Yes, I want to participate**
☐ **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**

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.

☐ **Yes, I want to participate**
☐ **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** _____