



ENROLLMENT FORM – FLEXIBLE SPENDING ACCOUNTS

NEW YORK MEDICAL COLLEGE
January 1, 2012 - December 31, 2012

GENERAL INFORMATION:

Employee Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
E-mail address: _____
Social Security Number: _____
Date of Birth (MM/DD/YYYY): _____
Date of Hire (MM/DD/YYYY): _____

FLEXIBLE SPENDING ACCOUNTS:

. I hereby elect to participate in the Flexible Spending Accounts

	Per Pay Period (*Minimum Annual Election = \$260)	# Pay Periods	=	Annual Election* (\$5,000 Maximum)
Health Care Reimbursement	\$ _____	x <u>26</u>	=	\$ _____
Dependent Care Reimbursement (Day care expenses incurred during employment hours)	\$ _____	x <u>26</u>	=	\$ _____

Effective date of coverage: _____ The first payroll deduction will be on _____, 20__.

My pay schedule is: . weekly . bi-weekly . semi-monthly . monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Flexible Spending Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Date _____ Employee Signature _____

Please return this form to your Employer.