

**Employee Enrollment Form - Flexible Spending Account**

W.S. Badger Company, Inc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Employer Name Start Date Date of Hire Start Deductions Employee Dept.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Last Name First Name M.I. Social Security #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Mailing Address City State Zip Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address Home Phone Number

***Dependents***: Gender

Name: Social Security #: Relationship: Date of Birth: M/F:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_\_

**Medical Care Reimbursement Account (MCRA)**

YES, I choose to participate in the MCRA:

My total election for 2022 is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_ per pay period X\_\_\_\_\_\_\_pay periods = $\_\_\_\_\_\_\_\_\_ (total election)

(Max $2,850.)

YES, please send me a Benny Debit Card. (If I need additional cards or if my cards are lost or stolen I will be charged a $5 fee which will be debited from my annual election.)

**Dependent Care Reimbursement Account (DCRA)**

YES, I choose to participate in the DCRA and understand that an eligible dependent for the purposes of this account is a dependent child under age 13 or a tax dependent or spouse of any age who is physically or mentally incapable of self-care.

My total election for 2022 is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_ per pay period X\_\_\_\_\_\_\_pay periods = $\_\_\_\_\_\_\_\_\_ (total election)

(Family maximum $5,000)\*

\*If married and filing a joint income tax return, total amount cannot be more than the lesser of the earned income of the employee or their spouse. If married and spouse is a full-time student or incapable of self-care, the deemed earned income for spouse is $250 a month for one dependent or $500 a month for more than one dependent.

**Signature Accepting Participation**

I understand that:

•I may not change or stop my payroll deductions for the reimbursement account election(s) during the plan year unless my family status changes, and that only new elections requested within 30 days of my status change which are consistent with the change will be permitted. •I understand my total election will be deducted in equal amounts from my regular paycheck beginning with the first pay period after enrollment in the plan and ending with my last paycheck in the plan year.

•I may carry over up to $570 of unused amounts remaining in my MCRA at the end of the plan year, to be used for eligible expenses incurred during the next plan year; otherwise, unused amounts that remain after reimbursing eligible expenses incurred during the plan year will be forfeited. •Any unused amounts that remain in my DCRA after reimbursing eligible expenses incurred during the plan year forfeited.

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Employee Signature Beneficiary (please print) Relationship

**Signature Declining Participation**

NO, I choose not to participate in the MCRA for 2022

NO, I choose not to participate in the DCRA for 2022

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Employee Signature

**Health Plans, Inc.**  PO Box 5199, Westborough, MA 01581 877-734-7004