



Peralta Community College District

Flexible Benefits Plan Enrollment Form

Plan Year: 1/1/2012 through 12/31/2012

If you wish to participate in any portion of the flexible benefit plan you must complete the following section. You may elect to participate in one, or any combination of the three benefits out lined below.

Return this completed form to your Benefits/ Human Resources Representative

SECTION A – EMPLOYEE DATA (PLEASE PRINT OR TYPE)		
Name:	SSN:	Home Phone:
Street Address:		
City:	State:	Zip Code:
DOB (date of birth):	Date of Hire:	Date of <u>First Contribution</u> (payroll date):
Email (required):		

SECTION B – Dependent Information- Please list your **Dependent Information** below:

Spouse: _____ DOB: _____ Dependent: _____ DOB: _____

Dependent: _____ DOB: _____ Dependent: _____ DOB: _____

SECTION C - I ELECT TO PARTICIPATE IN THE PLAN. I authorize my employer to reduce my salary by the amounts indicated below.

- COMPANY SPONSORED INSURANCE PREMIUMS**
I understand my employer will reduce my salary on a pre-tax basis to pay for my share of the premium for those Health Insurance benefits in which I have enrolled on separate benefit enrollment form(s). If I wish to change this I must tell my payroll department in writing prior to the first of the plan year.
- MEDICAL REIMBURSEMENT ACCOUNT (annual maximum of \$2500.00 each plan year)** YES NO
This includes all eligible health related expenses not covered by my health insurance or any other benefit plan for me and my dependents. *This account does NOT cover any type of Insurance Premiums.*
I elect \$ _____ as my ANNUAL Medical Reimbursement election for 01/01 - 12/31.

<p><i>For office use only</i> \$ _____ / _____ = _____</p> <p style="text-align: center;"><i>Annual Election remaining pay periods per paycheck contribution</i></p>
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- DEPENDENT DAYCARE ACCOUNT** YES NO
If you are single, or married and file a joint return, *you may not have more than \$5,000 in this type of account per calendar year. This limit is reduced to \$2,500 if you are married and file a separate return.* Only dependent children under age 13 (unless physically or mentally handicapped) and/or a dependent adult requiring daycare qualify. Care must be for the hours when you and your spouse (if any) are at work.
I elect \$ _____ as my ANNUAL Dependent Care election for 01/01 - 12/31.

<p><i>For office use only</i> \$ _____ / _____ = _____</p> <p style="text-align: center;"><i>Annual Election remaining pay periods per paycheck contribution</i></p>
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- I understand that:**
- ❖ I cannot change this election during the plan year unless I undergo a change in family status.
 - ❖ Any unused funds left in my account at the end of the plan year are forfeited.
 - ❖ If I terminate my employment, whether voluntarily or involuntarily, and do not elect to COBRA my Medical Reimbursement Account, I can only submit expenses incurred prior to my termination date.
 - ❖ My Social Security Benefits/Disability may be affected by this election.
 - ❖ I cannot claim a tax credit for any expenses paid for by this Plan.
 - ❖ If I elect to participate in the Dependent Daycare Account I must file IRS Form 2441 with my tax return.
 - ❖ This election replaces any prior elections and will terminate at the end of the plan year, or if this plan is terminated.

Employee Signature: _____ Date: _____