

Orange County Community College PG Blue - FSA Enrollment Form

Your Account Information Is Online
www.ThePreferredGroup.com

— Please Read and Fill Out Carefully

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
 Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information			
Employer Group # 10484	Employer Group Name Orange County Community College	Plan Year 1/1/2021 to 12/31/2021	Social Security Number _____ - ____ - ____
Employee Name (First Name) _____		(Last Name) _____	
Employee Address (Street, Apt. #) _____			Date of Birth (mm/dd/yyyy) ____/____/____
Employee Address (City, State, Zip Code) _____, _____, _____			
Home Phone _____	Cell Phone _____	Email Address (Please allow email from benefitsinfo@thepreferredgroup.com) _____	
Section 2 Flexible Spending Plan Benefit Elections			

Please return to the Human Resource Department.

Account Type	Fund#		New Election		
MEDICAL FSA Min \$300; Max \$2,750 (\$500 carryover applies)	1				
DEPENDENT DAY CARE (\$5,000 max/\$2,500 if married, filing separately)	2				

Section 3 Reimbursement Options	
If you wish to have your reimbursements directly deposited to your bank account, please fill in the line below.	
Direct Deposit Setup: Bank Name _____	Routing # _____ Acct # _____
Initial to Request Debit Card _____	

Please note: By entering the above information you are enrolling into these specified programs and are validating your dependent information. For more information on these options including the timing of reimbursements, please see your Summary Plan Description.

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules

Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I am only entitled to the amount of the above elections and cannot change any of my elections during the plan year (unless I have an acceptable change in status), and that any money left in my account(s) at the end of the plan year will be treated in accordance with my employer's FSA plan document.

Employee Signature _____	Date _____
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Section 5 Employer's Section — Payroll Information for Salary Reduction Changes					# Payrolls	26
Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct	Use 'First Payroll Date' and employer signature ONLY if the employee is making a mid-year election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an old election or termination.	
FSA						
DCA						
Employer Signature _____					Date _____	