

## County of Orange PG Blue - FSA Enrollment Form

Your Account Information Is Online  
[www.ThePreferredGroup.com](http://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

<b>Section 1 Employee Information</b>			
Employer Group # <b>10483</b>	Employer Group Name <b>County of Orange</b>	Plan Year <b>1/1/2022 to 12/31/2022</b>	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) _____	
<b>Section 2 Flexible Spending Plan Benefit Elections</b>			

# Please return to the Human Resource Department.

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

<b>Section 3 Reimbursement Options</b>
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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<b>Section 5 Employer's Section — Payroll Information for Salary Reduction Changes</b>					<b># Payrolls</b>	<b>26</b>
Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct	<b>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.</b>	
FSA						
DCA						
Employer Signature _____					Date _____	