



Broome-Tioga BOCES PG Blue - FSA Enrollment Form

Your Account Information Is Online
www.ThePreferredGroup.com

— Please Read, Complete & Return to Julie Mroz by September 18, 2015

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 # 10019	Employer Group Name Broome-Tioga BOCES	Plan Year 10/1/2015 to 9/30/2016	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

I understand that my Medical Insurance Premium is being paid on a pre-tax basis for this and subsequent years, unless I submit a declination form to the payroll office. I understand that this will not affect my coverage, timing of payment, or any other benefit offered by the Broome-Delaware-Tioga BOCES.

Not applicable, I am currently not covered by the insurance plans offered by the Broome-Delaware-Tioga BOCES.

Account Type	Fund#	New Election	New Election	New Election	New Election
MEDICAL FSA (\$2000 max)	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 # _____

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

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 <i>mid-year</i> election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an <i>old</i> election or termination.
FSA					
DCA					

Employer Signature	Date
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