WageWorks®

P.O. Box 1840, Tallahassee FL 32302-1840

Enrollment/Change In Status Form

STATE OF NEW JERSEY

PLAN YEAR 1/1/2014–12/31/2014

FAX to 1-866-672-4780

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SOCIAL SECURITY #	HOME PHONE ( )	WORK PHONE (W/ EXTENSION IF APPLICABLE) ( )
LAST NAME	FIRST NAME	MI
ADDRESS (STREET)	CITY	STATE / ZIP
BIRTH DATE / / ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ FULL-TIME ☐ PART-TIME	DATE EMPLOYED / / ☐ 10-MONTH EMPLOYEE ☐ 12-MONTH EMPLOYEE	E-MAIL ADDRESS

SELECT YOUR EMPLOYER AGENCY BELOW:

- ☐ State Agency (Centralized Payroll)
- ☐ The Legislative Group *(CS26)*
- ☐ Palisades Interstate Park Commission *(00330)*
- ☐ Rowan University *(00410)*
- ☐ New Jersey City University *(00411)*
- ☐ Kean University *(00412)*
- ☐ William Paterson University *(00413)*
- ☐ Montclair State University *(00414)*
- ☐ College of New Jersey *(00415)*
- ☐ Ramapo College of NJ *(00420)*
- ☐ Richard Stockton College of NJ *(00421)*
- ☐ Thomas Edison State College *(00430)*
- ☐ New Jersey Institute of Technology *(32700)*
- ☐ Rutgers University -formerly UMDNJ employees(00497)
- ☐ Rutgers University *(90010)*
- ☐ New Jersey Building Authority *(39900)*
- ☐ University Hospital (00498)

ENROLLMENT STATUS: ☐ NEW ENROLLMENT ☐ RE-ENROLLMENT ☐ CHANGE IN STATUS

INSTRUCTIONS

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HOW TO ENROLL IN THE FLEXIBLE BENEFITS PLAN:
Indicate any benefits in which you want to participate by completing Section 3 below. Enter the corresponding annual election amount in the column to the right of the benefits you have chosen.
RETURN YOUR COMPLETED ENROLLMENT FORM TO WageWorks at above address or fax to 1-866-672-4780.

FLEXIBLE BENEFITS

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Indicate all selections by entering the necessary information below. You must enter an amount under ANNUAL ELECTION AMOUNT to receive the corresponding benefit.

MEDICAL EXPENSE PLAN BENEFITS*	ANNUAL ELECTION AMOUNT
Unreimbursed Medical Expense election for Participants and Dependents - A calculator is available in the Reference Guide to help you calculate your annual contribution.	

DEPENDENT CARE PLAN BENEFITS* (Ex: childcare, summer day camp (children age 12 and under), adult day care)	ANNUAL ELECTION AMOUNT
Dependent Care Flexible Spending Account - A calculator is available in the Reference Guide to help you calculate your annual contribution. **Tax Filing Status [Please Check One]:** ☐ Married, filing separately **[maximum—$2,500]** ☐ Married, filing jointly **[maximum—$5,000]** ☐ Single, head of household **[maximum—$5,000]**	
COMBINED MEDICAL EXPENSE AND DEPENDENT CARE TAX-FREE SALARY DEDUCTION AMOUNT	$

* For a Medical Flexible Spending Account (FSA) the minimum annual contribution is $100 with a maximum annual contribution of $2,500. For a Dependent Care Flexible Spending Account (FSA) the minimum annual contribution is $250. The maximum annual contribution for a Dependent Care FSA is $5,000; however, to determine if you qualify for the full amount, please see your Reference Guide for more information.

CHANGE IN FAMILY STATUS

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DATE OF CHANGE IN FAMILY STATUS: ______________

DUE TO: ☐ **Marriage** ☐ **Divorce** ☐ **Birth or legal adoption of child** ☐ **Death of dependent** ☐ **Change in work status of spouse** ☐ **Significant change in health coverage due to spouse's employment** ☐ **Change in cost or coverage of Dependent Care**

CHANGE - Please complete the following:

☐ I elect to change my Annual Salary Deduction Amount from $__________ to $__________ for the Unreimbursed Medical Spending Account due to a Change in Family Status.

☐ I elect to change my Annual Salary Deduction Amount from $__________ to $__________ for the Dependent Care Spending Account due to a Change in Family Status.

I hereby authorize my Employer to reduce my gross salary (before federal income and Social Security taxes are calculated) by the total annual election amount of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this Plan Year CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO MY EMPLOYER.

The total tax-free salary deduction amount specified above will continue in effect for the period of this plan year unless I discontinue or modify my Agreement through terminating employment or taking an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT MY EMPLOYER, UNION AND WAGEWORKS, THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN THE FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Employer or Employer's designee to serve as Agent to receive any funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs or for such other purpose as permitted under applicable state and federal law.

When enrolling in either or both FSAs, written notice of agreement with the following will be required: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

IMPORTANT: I understand that if I elect not to participate in salary reduction with respect to the FLEXIBLE BENEFITS PLAN benefits listed in Section 3 above, I hereby forego my rights to participate at this time.

EMPLOYEE SIGNATURE	DATE SIGNED

ADMINISTRATOR USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES