# 2024 Open Enrollment Flex Facts Enrollment Form

Please return this form to your human resources representative

**Personal Information**

Employer: Mercer County Community College

Full Name:

*Last First M.I.*

Address:

*Street Address Apartment/Unit #*

*City State ZIP Code*

Phone: Social Security Number:

Birth Date: E-mail Address:

Effective Date: Plan Year Start: January 1, 2024

**Benefit Election**

|  |  |  |  |
| --- | --- | --- | --- |
| **I ELECT THE FOLLOWING:** | **Amount Per Pay Period** | **# of Pay Periods** | **Annual Election** |
| Medical FSA Account Dependent Care Account Transit Account Parking Account | $ $ $ \_\_\_\_\_\_\_\_\_\_\_\_\_$  |   | $ $ $\_\_\_\_\_\_\_\_\_\_$ \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Frequency of Pay:** | Weekly | Bi-Weekly |  X Semi-Monthly | Monthly | Other |

**Date of First Deduction:**

**Spouse or Dependent Card Information\***

 ***\*Utilize next page to add additional dependents***

Full Name:

*Last First M.I.*

|  |  |  |
| --- | --- | --- |
| Mail Card to: | Address listed above | Alternate Address:  |
|  |  | *Street Address* | *Apt. /Unit #* |
| Date of Birth: |   |   |   |   |
|  |  | *City* | *State* | *ZIP Code* |

Soc. Sec. Number: Relationship:

**Employee Authorization**

* + If this form is not returned to your employer by your effective date, you will not be able to participate in the plan until the following plan year.
	+ Your accounts will not automatically renew. You must sign a new election form each year at open enrollment.
	+ You cannot change the FSA election during the plan year unless you have an eligible change in status.
	+ This agreement is subject to the terms of the company’s Flexible Benefits Plan.
	+ By signing this form, I agree that my cash compensation will be redirected by the amounts set forth above.

Signature: Date:

Flex Facts | 1200 River Avenue, Suite 10E | Lakewood, NJ 08701 | [www.flexfacts.com](http://www.flexfacts.com/) | 877-94-FACTS

# Flex Facts Enrollment Form

Employee Name:

 *Last First M.I.*

Employee SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Additional Dependents

Full Name:

*Last First M.I.*

|  |  |  |
| --- | --- | --- |
| Mail Card to: | Address listed above | Alternate Address:  |
|  |  | *Street Address* | *Apt. /Unit #* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Birth: |   |   |   |   |
|  |  | *City* | *State* | *ZIP Code* |

Soc. Sec. Number: Relationship:

Full Name:

*Last First M.I.*

|  |  |  |
| --- | --- | --- |
| Mail Card to: | Address listed above | Alternate Address:  |
|  |  | *Street Address* | *Apt. /Unit #* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Birth: |   |   |   |   |
|  |  | *City* | *State* | *ZIP Code* |

Soc. Sec. Number: Relationship:

Full Name:

*Last First M.I.*

|  |  |  |
| --- | --- | --- |
| Mail Card to: | Address listed above | Alternate Address:  |
|  |  | *Street Address* | *Apt. /Unit #* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Birth: |   |   |   |   |
|  |  | *City* | *State* | *ZIP Code* |

Soc. Sec. Number: Relationship: