

**FLEXIBLE SPENDING ENROLLMENT FORM**

We recommend eligible employees review enrollment materials whether electing benefits, keeping benefits the same, making changes, or waiving enrollment. The elections you make will remain in effect until the end of the plan year unless you experience a life change event.

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| 1. **EMPLOYEE INFORMATION**
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| --- | --- | --- | --- | --- | --- |
| **First Name** | **Initial** | **Last Name** | **Social Security**  | **Birth Date** | **Gender** |
|   |  |   |   |   |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Street Address** | **Unit** | **City** | **State** | **Zip** |
|  |  |  |   |   |

|  |  |  |  |
| --- | --- | --- | --- |
| **Email Address** | **Phone** | **Position** | **Location** |

|  |  |  |
| --- | --- | --- |
| **FLEXIBLE SPENDING ACCOUNT** | Bi-weekly  | Annual  |
| **Health Care Account** *(Elect an annual amount between $100 and $3,200)* | $ | $ |
| **Dependent Care Account** *(Elect an annual amount between $100 and $5,000)* | $ | $ |

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| 1. **COORDINATION OF BENEFITS**
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While you are covered under a William Penn policy, will you or any family members covered under this plan have other health insurance or medical coverage? Yes or No. If “Yes,” you must fully complete the following section. Starting with the employee, list each family member applying for coverage and include information for all previous coverage in effect. If your coverage is still in effect, please write “current” or “present” in the end date field.

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date** | **End Date** | **Insurance Company** | **Names of Covered Members** |
|  |  |  |  |
|  |  |  |  |

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| 1. **MEDICARE INFORMATION**

***(Coordination of benefits is required if Medicare eligible employees & dependents)***  |

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\_\_\_\_

**Does Medicare cover you, your spouse or any dependent? Select “Yes” or “No” here:**

**If “Yes,” please attach a copy of each Medicare ID card and complete the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee** | **Effective Date** | **Spouse** | **Effective Date** |
| **Part A** |   | **Part A** |   |
| **Part B** |  | **Part B** |  |
| **Part D** |  | **Part D** |  |

**Sign and return to Human Resources with all required documents.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Human Resources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**