

Accrue CMS

EMPLOYEE ENROLLMENT FORM

Company Name:		Name:			
Address:		City:	State:	Zip Code:	Hire Date:
Date of Birth:	Gender: ☐ Male ☐ Female	Phone Number:		Email Address:	
Social Security Number:					

Note: **Election changes are only allowed with a qualifying change of status event. Changes requests must be submitted within 30 days of the event.**

Pay Period: (Check the box which indicates the frequency of your paychecks)

☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ OTHER

FSA Health Care Annual Election ☐ Full FSA ☐ Limited FSA

\$ _____
(\$3,500 annual maximum)

FSA Dependent Care Annual Election*

\$ _____
(\$7,500 maximum family,
\$3,750 maximum per spouse if married filing separately)

Commuter - Transit Monthly Election

\$ _____
(\$350 maximum)

Commuter - Parking Monthly Election

\$ _____
(\$350 maximum)

☐ I decline to participate

I hereby authorize my election(s) for the benefit(s) designated above for the plan year. I understand that my pay will be reduced by the elected amounts. I understand that these elections are annual elections (FSA and dependent care) or monthly elections (transit and parking) and cannot be changed except in the case of a qualifying event. I understand that any unused balance in any benefits at the end of the plan year or upon my termination of employment is subject to forfeiture.

Employee Signature: _____ Date: _____

*Dependent Care is for daycare(baby-sitting) of children or elderly dependents. It is not for medical expenses for your dependents