Accrue CMS

EMPLOYEE ENROLLMENT FORM

Company Name:			Name:		
Address:		City:	State:	ZipCode:	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

$ **($3,500 annual 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 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.

ACCRUE CMS

Employee Signature: _____ **Date:** _____