

**SUFFOLK COUNTY**  
**FLEXIBLE BENEFITS ENROLLMENT FORM**  
**PLAN YEAR: 1/1/12 – 12/31/12**



**M.A. Services**  
 PO Box 587  
 Pittsford, NY 14534  
 (800) 836-8100 or (631) 863-8887  
 FAX: (585) 248-2488

YOU MAY ALSO ENROLL ONLINE AT [WWW.FLEXBENE.COM](http://WWW.FLEXBENE.COM) EMPLOYER PASSCODE: SUFFOLK

EMPLOYEE INFORMATION (Please Print)														
Employee Name:		Employee SSN:		Birth Date:										
		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										Month	Day	Year
Address:		City:		State:		Zip:								
Email Address: (All communications will be sent to this address unless not provided.)				Daytime Telephone:										
Gender:	Marital Status:	Date Employed:		Employment Status:	You must check one:									
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	Month	Day	Year	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	<input type="checkbox"/> College <input type="checkbox"/> County	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-Enrollment							
						Department Name								

DEPENDENTS (Please Print)				
Name	Relationship	Gender	Birth Date	Social Security #
	spouse (federally acknowledged)			

I AUTHORIZE my spouse or the following representative to discuss my account:  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

- \*\*\* IMPORTANT \*\*\* By enrolling in the Flexible Benefits Plan I understand that:
- I will be paid from the Flexible Spending Account(s) upon submission of properly prepared claim forms.
  - I may not change my election during the Plan Year unless I experience a change in status.
  - I may not transfer money between options.
  - I will forfeit any balance remaining after year end.

EMPLOYEE ELECTIONS			
Please note: For those employees on the regular 26 pay period schedule the County takes deductions over 25 pay periods, no deduction will be taken the first pay period of 2012. If you are not on the 26 pay period schedule please be sure to indicate your number of pay periods below.			
Benefit Election Options	Participation	Salary Reduction Amount	
<b>Unreimbursed Medical, Dental, Vision Expenses</b> Maximum of \$6,000 per Plan Year	YES <input type="checkbox"/> NO <input type="checkbox"/>	\$ _____ per pay period	No. of pay periods during the Plan Year <b>25</b> \$ _____ per Plan Year
<b>Dependent Care Expenses</b> (includes daycare, summer day camps & before/after care services) Maximum of \$5,000 per Plan Year / \$2,500 if married filing separately	YES <input type="checkbox"/> NO <input type="checkbox"/>	\$ _____ per pay period	No. of pay periods during the Plan Year <b>25</b> \$ _____ per Plan Year
<b>Adoption Assistance</b> Maximum of \$10,000 per Child	YES <input type="checkbox"/> NO <input type="checkbox"/>	\$ _____ per pay period	No. of pay periods during the Plan Year <b>25</b> \$ _____ per Plan Year
<b>Individual Disability/AFLAC Premium*</b> Maximum enrollment equals cost of coverage	YES <input type="checkbox"/> NO <input type="checkbox"/>	\$ _____ per pay period	No. of pay periods during the Plan Year <b>25</b> \$ _____ per Plan Year
<b>Other Health Insurance (COBRA, etc.)</b> Maximum enrollment equals cost of coverage	YES <input type="checkbox"/> NO <input type="checkbox"/>	\$ _____ per pay period	No. of pay periods during the Plan Year <b>25</b> \$ _____ per Plan Year
<b>PBA Group Insurance Reductions</b> Please note that this is not a reimbursement account. It is the election to have the PBA Major Medical Deduction taken pre-tax. Must be a member of the PBA to enroll. If you are already enrolled it will be automatically carried over from year to year.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Single \$ <u>4.68</u> per pay <input type="checkbox"/> Family \$ <u>10.84</u> per pay	

\* Please discuss ANY pre-tax premium payments with your tax advisor OR agent to determine future tax liabilities.

AUTHORIZATION: I certify the above information to be correct and true to the best of my knowledge and that the children listed above either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any remaining dollars in my account(s) not used for eligible expenses incurred in the elected category, during the Plan Year, will be FORFEITED in accordance with current Plan provisions and tax laws. I understand that the Flexible Compensation reduction(s) will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status or terminate employment. (See printed SPD). I ALSO UNDERSTAND THAT THE FLEXIBLE COMPENSATION REDUCTIONS MAY HAVE SOME EFFECT ON MY SOCIAL SECURITY RECEIPTS. To compensate for this I have been offered a supplemental company retirement or deferred compensation plan.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN ENROLLMENT FORM TO M.A. SERVICES BY DECEMBER 15, 2011