



# BENEFITS ENROLLMENT FORM

Email: Benefits@MMChr.com

Please print this form, sign, and return to your employer for processing. Fax: 310.360.5100 | Phone: 800.899.6624

EMPLOYEE INFORMATION					
Employee Name:	Last Name		First Name		Middle Initial
Social Security Number:			Date of Birth:	Gender:	
Home Address:	Street		City	State	Zip Code
Email Address:			Telephone #:		

EMPLOYER/BENEFITS INFORMATION				
Employer Name:			Date of Hire:	
Plan Effective Date:			Date of 1 <sup>st</sup> Payroll Deduction:	
Insurance Carrier Name:				

Plan Type	Annual Election (\$)	Number of Payrolls	Amount per Pay Check (\$)	Employer Contribution (if applicable)	
				Per Month	Per Year
<input type="checkbox"/> Healthcare Flexible Spending Account (FSA):					
<input type="checkbox"/> Dependent Care FSA:					
<input type="checkbox"/> Limited Plan FSA (Dental and Vision Only):					
<input type="checkbox"/> Health Reimbursement Arrangement (HRA):					
<input type="checkbox"/> Health Savings Account (HSA):					
<input type="checkbox"/> Transportation Benefit Account:					
<input type="checkbox"/> Parking Benefit Account:					

FOR DEPENDENT COVERAGE:		Married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, list your spouse and dependent children below:	
		Dependent Children? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last Name	First Name	Social Security Number*	Relationship to Employee	Date of Birth*	Gender

AUTHORIZATION	
<p>I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws.</p> <p>Furthermore, I agree that the IRS regulations state four conditions: (1) any expenses I/we incur must be within the Plan Year; (2) any expenses I/we incur must not be covered by any other sources, such as insurance; (3) I/we must provide proper documentation to receive payment; (4) I/we cannot change or revoke elections during the Plan Year unless there is a specific change in status and my employer allows such changes. Please see Summary Plan Description for details.</p>	
Employee Signature	Date

\* Social Security and date of birth for employees and their dependents are required for HRA reporting purposes to the Centers for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Enrollment Forms without this required information will be returned for completion.