



Admin Fee \$5.50/month

ENROLLMENT FORM

2018 Contribution Limits: Healthcare FSA: \$2,650; Dependent Care FSA: \$5,000 (per household), Transit/Parking: \$260/mo. Health Savings Account (HSA): \$3,450 Individuals / \$6,900 Family
Please note: Highly compensated employees (earning \$120K+/year), owners, or owner's family members are not eligible for MMC's sponsored FSA.

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 st Payroll Deduction:	
Insurance Carrier Name:				

PLAN ELECTIONS					
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"/> Health Savings Account (HSA):					
<input type="checkbox"/> Transportation Benefit Account:					
<input type="checkbox"/> Parking Benefit Account:					
<input type="checkbox"/> I Do Not Want to Enroll					

This plan requires re-enrollment each year. If you do not re-enroll within the Open Enrollment period, your plan will not continue in the following year.

FOR DEPENDENT COVERAGE:		Married?	Dependent Children?		If Yes, list your spouse and dependent children below:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<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.