2019 Contribution Limits: Health Savings Account (HSA): $3,500 Individual, $7,000 Family Healthcare FSA: $2,700; Dependent Care FSA: $5,000 (per household); Transportation/Parking: $260 Please note: Highly compensated employees (earning $120K+/year), owners, or owner's family members are not eligible for MMC's sponsored FSA.

Admin Fee $5.50/month

BENEFITS ENROLLMENT FORM

Email: Benefits@MMChr.com
Fax: 310.360.5100 | Phone: 800.899.6624

Please print this form, sign, and return to your employer for processing.

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 1st 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
❑ **Healthcare Flexible Spending Account (FSA):**					
❑ **Dependent Care FSA:**					
❑ **Limited Plan FSA *(Dental and Vision Only):***					
❑ **Health Reimbursement Arrangement (HRA):**					
❑ **Health Savings Account (HSA):**					
❑ **Transportation Benefit Account:**					
❑ **Parking Benefit Account:**					

FOR DEPENDENT COVERAGE: **Married?** ❑ Yes ❑ No **Dependent Children?** ❑ Yes ❑ No — ***If Yes*, list your spouse and dependent children below:**

Last Name	First Name	Social Security Number*	Relationship to Employee	Date of Birth*	Gender

AUTHORIZATION

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.

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.

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.*