

## CITY OF WATERBURY, CT FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

A. Emplo	yee Ir	formation						P	lease Print Clearly!	
Name:						Social Security Number (Required):				
Home Addr										
City: State:				Zip Code:			Day Phone:			
E-mail Address:							Date of Birth:			
B. Flexible	e Bene	efit Plan Pre-tax	(Elect	ions				<del>-</del>		
1. Healt	th Car	e Reimbursem	ent Ac	<b>count</b> Eligible	figalth ention c	expenses Indude Calseage or for	professional Le numbre	intedical expenses incurred by my de deatlesubs apyachtistures or function	spendents or myself during .	
\$			x			\$	<b>F</b>	Election allo	wed	
Your Contribution Per Pay Period				of Pay Periods		Total Election		\$100 minimum/\$2,650 maximum		
2. Depe	ndent	Care Assistan	ce Aci	<b>count</b> Eligible Jire vou to disclos	dependa e the Ta	ent day care expe x ID or Social Sec	nses are inc. urdy Nombe	ulmed to allow you and your spause ( cof your day care provider(s) when	if applicable) to be gainfully.	
\$			×		= :			Election allo \$100 minimum/\$5,00	wed	
Your	Your Contribution Per Pay Reriod			of Pay Periods	<u> </u>	Total Election		(\$2,500 if married filin		
C. FlexExp	press(	Debit Card The	FlexExpre	ess Cards o are oot	ional. If	you and/or your	dependents l	have debit cards, they will autom <u>ati</u>	<u>cally</u> be reactivated unless	
you indicate bett	* If yo auton	ou conos want cares u ou and/or your depe natically reactivated t from below:	have debit card	is, they						
Check One:	0	I am a new particij debit cards.	is plan and wou	ld like a	This is for brand new participants on you already have cards, selecting this inactivate your existing cards.					
	o	I have cards that v replacement set of	stolen or dama	ged an	d would like a		this option will <u>Inactivate and re</u> aplacement cards are \$5 per set			
	0	I do NOT want FlexExpress Cards.					Your default reimbursement method will be check unless the direct deposit information below is completed.			
Additional start), Please not	Card te that ca	Information: এন res are ordered in mut	ase industri room of 2.	ite sho iumber of Téxanale: 2, 4, 6	adadjaj . 8. etc	iai canes you word 1 Ade Tional sets a	ic lake tid red tire \$5 per so	orest broom (If you request a card fo	r yourself you will get 2 to	
		onal Sets Reque								
D. Direct D	Deposi	it Authorization	If you we	ould like non debit	cardine	imbursements to	he directice	posted to your hank account (rathe	r than receiving paper	
checks) fill out the information below EACH PLAN YEAR AND attach a voided che				d check	Checking Ac	ng Account SA		fefaulted to check.		
Bank Name: (See #1 on sample)				0	Savings Acco	Account Hadder's Marie Address Co.		ONESTANIA Transaction 40/25-40/09		
Routing Number - 9 digits (See #2 on sample): Account Num						er (See #3 on s	sample):	Section Section 1 - Constitution 1 - Con	904( 638	
<ul> <li>Loramet</li> <li>I must nileuring therefore</li> <li>For expense in the IRS</li> </ul>	change I nake all bi ne Plan Y it back, enses rein i requires	ear. Any money unclain	on Year s and conse- ned from a count licer and of all n	inless I have a cur- rvatively. Expenses ny reimbursement rify I have not been ny expenses claim	dify.ag d sifrom R account uire nibu od and s	simbursement Ac (s) at the end of the use:I and will not s supply them to Ber	counts asasi no Pieri Year seek reimbur	of be reimbursed from any other sour will be forfeited to my employer after somer t under any other plan enverin as if requested.	a run-out period. I will not	
Employee Signature (required):								Date:		
Employer Acceptance (required):								Benefit Effective Date:		
*If this is a mid-year enrollment, please list the first payroll date for deductions.								First Payroll Date:		



## CITY OF WATERBURY, CT LIMITED PURPOSE FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

Α.	A. Employee Information					Please Print Clearly!					Instructions on Back	
Name:						Social Security Number (Required):						
	ne Addr						-		<b>,</b>	(		
Check	c If New: [	J .					<u>-</u>				,	
City	ity: State:				Zip Code:			<u> </u>	Day Phone:			
E-m	all Add	ress (F	Required):							Date of Birth:		
В.	Flexib	le Be	nefit Plan Pre-	tax	x Elections				•	-	1011 0	
1.	Limi	ted P	urpose Health	C -	ire Account		e ex	censes include p	rofessional dental	and vision expenses incur	red by my dependents or myself.	
	during t	he Plan Y	ear for the diagnosis; c	xuren X	1		even \$		or for the purpose		e or (unation of the body".	
	Your Contribution Per Pay Period		^	# of Pay Periods		= 5 Total Election		Election Allowed \$100 Minimum / \$2,650 Maximum				
2.				ınc		eible:	depe			red to allow that and you	spause (if applicable) to be	
	gainrull	/employ	ed. Please remember th	at Ch	ie (RS:will require you	todis	clos	e the Tax ID or S	ocial Security Num	iber of your day care pro	dcerts) when you file your	
PRIHAN.	Ś		IN BRIDE TO CHECKHI HELD AND SON	X	\$90000000000000000000000000000000000000	] <u> </u>	\$		OCCUPATION NO DESCRIBER	Maximum Elec		
	Your Contribution Per Pay Period			# of Pay Periods	J	Ľ	Total Election		\$100 Minimum / \$5,000 Maximum (\$2,500 if married filing separately)			
C. /	FiexExp	oress!	Debit Card Iryo	u ale	ranow enrollee a set.	of 2 F	xF	xpress Cardon w	il be mailed out t		u and/or your dependents	
alread	y have deb	* If yo	they will <u>automatically</u> ou and/or your deper	der	nts have debit card	is, th	еу ч	vili be	ction lectow.			
Ob	- f- O		<u>natically</u> reactivated t from below:	your renewal. Oth	enewal. Otherwise, please			NO action required.				
Check One:										s option will inactivate and replace all of your existing		
		_	replacement set of						'	ment fee is no charge.		
Add to star	litiona ti. Please	l Card	<b>d Information:</b> Ceards are ordered mea.	Pleas itabl	se indicate the number of 2. (Example: 2)	a (d a 4, 6, 1	u <i>ldit</i> : 8. et	tonal card ayou y .c. )	vocal tike to requi	ist below i'll you request a	a card for yourself you will get 2	
Num	ber of	Additi	onal Sets Reques	tec	1;							
D. I	Direct	Depo	sit Authorizat	ion	I If you would like not	- deti	i car	d rei noursemen	ts to be direct de	aosted to your bank acco	unt (rather than reverying paper)	
		ne inform	iation below EACH RLAI	4 YE	AR AND atlach a void	1.	eck.	If you do not con Checking Acc		ian Eacli plan ye you wi	III be defaulted to encek	
Bank Name: (See #1 on sample)				$\vdash$	<u>.</u>			Address, Etc.	Vallet (konta): Vallet (konta):			
Routing Number - 9 digits (See #2 on sample):					Savings Account			diit.	26.10			
	ang Mum	DCI - 7	digits (see #2 oil s	amp	Accou	ınt N	lum	<b>ber</b> (See #3 o	n sample):	. Beek Information	TALES	
										Manne of Sanda Moldregg, Papers		
= 5	ianatu	YOS U	signing below, Lagrae to			Est.			-	8-1 Digit Rowter Muriber	1. The cities Associate Number 5	
	Leannot	change I	ihis etaction during the Pr	ar Y	fear unless Thave a du	idriyir	gich	auge in family st	stas.			
	curing ti	re Plan Y	'ear.								source and must be approach	
	use. Any	/ money (	unclaimed from my llealt	h Ça	are Reimbursement Ab	tds up counti	itop (s) at	zian limits al the e tithe end of the P	end of the plan year flan Year in excess	ir for deposit into the next act the carryover limits w	following plan year for future the formitted to my crimboych	
	<ul> <li>For expu</li> </ul>	enada reil	riod. will not receive it I mbursed through this are	count	t Lecrtify I have not bed	en reir	rbur	rsed and will not	seek reiniburseme	nt under any other plan co	overing health benefits	
	Thave re	requires sac and u	meito ksepidocumentati inderstood all of the olan	deta	i air ny expenses da n ils outlined in my Sum	neu si imary	nais. Plan	црау mem to вс. Description.	nen strategies i r	equested.		
Empl	oyee Sig	nature	(required):							Date:		
Empl	oyer Ac	ceptan	CO (required):							Effective Date:		
fif this is a mid-year enrollment, please list the first payroll date for deductions.						First Payroll Date:						
										DGCG,		