MERITAIN HEALTH
An Aetna Company

Axiom Resource Management, Inc.

FSA Enrollment Form

EMPLOYEE INFORMATION					BENEFIT ADMINISTRATOR SECTION	
LAST NAME	FIRST NAME		MI		PLAN YEAR 1/1/2018 – 12/31/2018	GROUP # 10982
MERITAIN HEALTH ID NUMBER/SSN	GENDER ❑ M ❑ F	DATE OF BIRTH			EFFECTIVE DATE	DIVISION #
HOME ADDRESS		EMAIL ADDRESS			DATE OF HIRE	
CITY	STATE	ZIP CODE			PAY CYCLE ❑ WEEKLY ❑ MONTHLY ❑ BI-WEEKLY ❑ SEMI-MONTHLY ❑ OTHER: ___________________	
HOME TELEPHONE	WORK TELEPHONE					

Please check all that apply:

❑ HEALTH FSA ❑ WAIVED

I would like to contribute $_________ per pay period ($__________ annually) to my Healthcare Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $2,650 per calendar year.

❑ DCAP ❑ WAIVED

I would like to contribute $_________ per pay period ($__________ annually) to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The maximum annual election allowed by the IRS is $5,000 per family or $2,500 per individual (or spouse when married and filing separate tax returns)

ELIGIBLE DEPENDENTS:

Dependent's Name (Last, First, MI)	Gender	Relationship	Birth Date
	❑ M ❑ F	Spouse	
	❑ M ❑ F	Child	
	❑ M ❑ F	Child	
	❑ M ❑ F	Child	

EMPLOYEE SIGNATURE REQUIRED

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

EMPLOYEE SIGNATURE	DATE