

ENROLLMENT/CHANGE FORM



**EMPLOYER NAME:** Rockford Area Schools

Plan Year: **January 1, 2022 - December 31, 2022**

Enrollment (Check one):  Open Enrollment  New Hire  Qualifying Event (Please provide) \_\_\_\_\_

**EMPLOYEE INFORMATION --- PLEASE PRINT CLEARLY**

Name: \_\_\_\_\_ Employee SSN Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Gender:  Male  Female Marital Status:  Married  Single

Preferred Reimbursement:  Check  ACH I Elect a Debit Card (New card is not issued if you already have one):  
 XX Yes, please issue  Yes, currently have a card  No

**\*\*Direct Deposit Sign Up – Read Carefully**

• By completing this section, you are requesting HR Simplified, Inc. to initiate Direct Deposit for all manual claims.

NAME OF BANK: \_\_\_\_\_  Checking  
 ACCOUNT NUMBER: \_\_\_\_\_  Savings  
 ROUTING NUMBER: \_\_\_\_\_

I authorize HR Simplified, Inc. to initiate credit entries and, if necessary, to initiate any debit entries to correct an erroneous credit entry to my account at the DEPOSITORY (identified above), for the purpose of automatically depositing funds to my account. I acknowledge that the origination of these transactions must comply with the provisions of U.S. Law.

I understand that this authorization replaces any previous authorization and will remain in full force and effect until HR Simplified, Inc. has received written notification from me of its termination in such time and in such manner as to afford the HR Simplified., Inc. and the DEPOSITORY a reasonable opportunity to act on it.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PLAN DESCRIPTION -- PLEASE READ CAREFULLY**

PLAN DESCRIPTION -- PLEASE READ CAREFULLY	Enroll	Payroll Amount	Election Amount	
<b>Health Care Reimbursement Account (FSA)</b> Includes all eligible health care expenses. Subject to annual maximum of \$2,850. Does not require participation in employer's health insurance plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____	<input type="checkbox"/> I elect to waive all pre-tax benefits under the Flexible Benefit Plan. Except for a Change in Status, I understand that I cannot elect pre-tax benefits until the next Anniversary Date and any after-tax coverage shall be outside the Plan.
<b>Dependent Care Reimbursement Account (DCA)***</b> *****Child is no longer eligible at age 13***** Includes all eligible dependent care expenses. Subject to annual IRS maximum of \$5,000 per Head of Household or married couple filing jointly.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____	
<b>Health Savings Account</b> Single maximum - \$3,650; Family maximum - \$7,300, 55 and over catch up \$1,000 – ER contribution, if any, must be included.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____	
<b>Limited Purpose Health Care Reimbursement Account (HSA Compatible FSA)</b> Covers only vision, dental, and medical expenses after your medical deductible has been met. Subject to annual maximum of \$2,850.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____	

**DEPENDENT INFORMATION \*\*(Please check a box in the Release of Information & Debit Card -- without your consent HR Simplified will not issue a card or release any information regarding your account to any dependent).\*\***

Name	SSN	Date of Birth	Relationship	Release of Information**	Debit Card (18 years+)**
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ADDITIONAL HSA INFO:** Driver's License #: \_\_\_\_\_ US Citizen?  Yes  No: \_\_\_\_\_ Mother's maiden name: \_\_\_\_\_ **Please fill out a Beneficiary form if other than spouse**

**PARTICIPANT SIGNATURE**

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY EMPLOYER ONLY:**

Effective Date: \_\_\_\_\_ Total pay dates remaining in the plan year: \_\_\_\_\_ First Payroll: \_\_\_\_\_ Employee Highly Compensated: \_\_\_\_\_ Employee Division: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Comments: \_\_\_\_\_