



Consumer Driven Account Enrollment Form

Applicant information

Company name _____ Group number _____ Location _____

Social Security number _____

First name _____ MI _____ Last name _____

Street address _____

City _____ State _____ ZIP code _____

Gender _____ Marital status _____ Date of birth / /
MM DD YYYY

Email _____ Phone number _____

Date of hire / /
MM DD YYYY

Plan effective date / /
MM DD YYYY

Payroll schedule ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly

Health care

Contribution per pay period	Number of pay periods remaining in plan year	Annual election amount
\$ _____	X _____	= _____ Cannot exceed IRS maximum

Dependent care

Contribution per pay period	Number of pay periods remaining in plan year	Annual election amount
\$ _____	X _____	= _____ Cannot exceed \$5,000 per household

Authorization

Please select your enrollment option below, then sign and date your form and submit to your benefit services department.

- ☐ I elect to participate in my employer's consumer driven account plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the plan year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire plan year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the current plan year may be forfeited depending on the terms of my employer's plan.

If the plan administrator determines that an expense I submitted for reimbursement was not a qualified expense under the plan documents, I will immediately reimburse the plan for the entire amount of the unqualified expense. If I fail to timely reimburse the plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the plan in order to reimburse the unqualified expense.

- ☐ I decline enrollment in my employer's consumer driven account plan.

Employee signature _____

Date / /
MM DD YYYY