MEDICAL MUTUAL

EMPLOYEE ENROLLMENT FORM

Flexible Spending Account (FSA)

Please sign, date, and complete each line on the enrollment form.

Return the completed and signed form to your employer for processing

INDIVIDUAL/Participant INFORMATION

First Name:_____ Last Name:_____

Email Address_____ Phone #_____

Address:_____ City_____ State:_____ Zip:_____

Date of Birth:_____

ANNUAL ELECTIONS

MEDICAL MUTUAL FLEXIBLE SPENDING ACCOUNT (FSA)

_____Yes I would like to participate.

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Please check the proper amount below that fits your situation.

_____$400.00 Single _____$800.00 Married or Dependents

If you wish to personally contribute, please indicate the amount below of your total annual contribution.

_____Total Annual Contribution

MEDICAL MUTUAL DEPENDENT/ELDER CARE ACCOUNT (DCA)

_____Yes, I elect to contribute for the PLAN YEAR to fund my account that pays qualified dependent day care or elder care expenses.

_____No, I decline this option for this plan year.

AUTHORIZATION

Important Please read the following before signing this enrollment form.

My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I understand that the Medical Mutual debit card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the Medical Mutual debit card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with the Medical Mutual debit card. i also understand that if a payment is made that is not for qualified expenses, I will repay my employer.
For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

EMPLOYEE SIGNATURE_____ DATE_____