WageWorks

Enrollment/Change In Status Form

STATE OF NEW JERSEY
PLAN YEAR 1/1/2017–12/31/2017

Mail to: P.O. Box 14766, Lexington KY 40512-4766

FAX to 1-866-672-4780

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SOCIAL SECURITY #	HOME PHONE	WORK PHONE (W/ EXTENSION IF APPLICABLE)
	( )	( )

LAST NAME	FIRST NAME	MI

ADDRESS [STREET]	CITY	STATE	ZIP

BIRTH DATE				DATE EMPLOYED		
/ /	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE	☐ FULL-TIME ☐ PART-TIME	/ /	☐ 10-MONTH EMPLOYEE ☐ 12-MONTH EMPLOYEE	E-MAIL ADDRESS

SELECT YOUR EMPLOYER AGENCY BELOW:

☐ State Agency (Centralized Payroll)	☐ New Jersey City University (00411)	☐ College of New Jersey (00415)	☐ New Jersey Institute of Technology (32700)
☐ The Legislative Group (CS26)	☐ Kean University (00412)	☐ Ramapo College of NJ (00420)	☐ Rutgers University (90010)
☐ Palisades Interstate Park Commission (00330)	☐ William Paterson University (00413)	☐ Stockton University (00421)	☐ New Jersey Building Authority (39900)
☐ Rowan University (00410)	☐ Montclair State University (00414)	☐ Thomas Edison State University (00430)	☐ University Hospital (00498)

ENROLLMENT STATUS: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ TRANSFER ☐ CHANGE IN STATUS* ☐ ERRONEOUS ENROLLMENT CORRECTION*

*Requires additional documentation

INSTRUCTIONS

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HOW TO ENROLL IN THE FLEXIBLE BENEFITS PLAN:

Indicate any benefits in which you want to participate by completing Section 3 below. Enter the corresponding annual election amount of the benefits you have chosen.

RETURN YOUR COMPLETED ENROLLMENT FORM TO WageWorks at above address or fax to 1-866-672-4780. Questions? Call Customer Service at 1-855-428-0446.

FLEXIBLE BENEFITS

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Indicate all selections by entering the necessary information below. You must enter a dollar amount to receive the corresponding benefit.

☐ I wish to enroll in the
MEDICAL EXPENSE PLAN BENEFITS

For uninsured eligible medical/dental/vision expenses incurred by you, your family members, or both (Minimum contribution is $100 per year; maximum allowable contribution is $2,500 annually).

Total Plan Year Dollar amount: $_____

THIS IS YOUR ANNUAL TAX-FREE SALARY DEDUCTION AMOUNT

☐ I wish to enroll in the
DEPENDENT CARE PLAN BENEFITS*

TAX FILING STATUS [PLEASE CHECK ONE]:

☐ Married, filing separately [maximum - $2,500]
☐ Married, filing jointly [maximum - $5,000]
☐ Single, head of household [maximum - $5,000]

Total Plan Year Dollar amount (minimum $250 per year): $_____

THIS IS YOUR ANNUAL TAX-FREE SALARY DEDUCTION AMOUNT

*** Eligible expenses for the care of eligible dependents include day care centers, private baby sitters, nursery schools, etc., but do not include expenses for medical care. Children are no longer eligible upon reaching age 13.**

CHANGE IN FAMILY STATUS

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/ /
DATE OF CHANGE IN FAMILY STATUS

DUE TO: ☐ Marriage ☐ Divorce ☐ Birth or legal adoption of child ☐ Death of dependent ☐ Change in work status of spouse ☐ Significant change in health coverage due to spouse's employment ☐ Change in cost or coverage of Dependent Care

CHANGE - Please complete the following:

☐ **I elect to change my Annual Salary Deduction Amount from $_____ to $_____ for the Unreimbursed Medical Spending Account due to a Change in Family Status.**

☐ **I elect to change my Annual Salary Deduction Amount from $_____ to $_____ for the Dependent Care Spending Account due to a Change in Family Status**

I hereby authorize my Employer to reduce my gross salary (before federal income and Social Security taxes are calculated) by the total annual election amount of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this Plan Year CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO MY EMPLOYER.

The total tax-free salary deduction amount specified above will continue in effect for the period of this plan year unless I discontinue or modify my Agreement through terminating employment or taking an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT MY EMPLOYER, UNION, AND WAGEWORKS, THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN THE FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Employer or Employer's designee to serve as Agent to receive any funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

When enrolling in either or both FSAs, written notice of agreement with the following will be required: 1) I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

IMPORTANT: I understand that if I elect not to participate in salary reduction with respect to the FLEXIBLE BENEFITS PLAN benefits listed in Section 3 above, I hereby forego my rights to participate at this time.

EMPLOYEE SIGNATURE	DATE SIGNED