

**Maumee Valley Presbytery**  
**Enrollment/Change Form for Dues-Share w/Health**  
**& Dependent Care Flexible Savings Plan For Plan Year 2018**

*Section A Employee, Spouse and Dependent Information*

**1 Employee Name:** \_\_\_\_\_  
First M.I. Last

**Address:** (Line 1) \_\_\_\_\_  
 (Line 2) \_\_\_\_\_  
 \_\_\_\_\_  
City State Zip

**Telephone Number:** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Employee's Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Employee's Soc. Sec. Number** \_\_\_ - \_\_\_ - \_\_\_  
Mo Day Year

**Marital Status:** \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Legally Separated

*2 Spouse Information*

**Name of Spouse:** \_\_\_\_\_  
First M.I. Last

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Soc. Sec. Number:** \_\_\_ - \_\_\_ - \_\_\_

*3 Dependent Information List all your Eligible Dependents:*

(Attach separate Sheet if necessary.)

First	MI	Last	Date of Birth	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Section B Annual Contribution Amount (January 1, 2018 - December 31, 2018)*

**Health Care Flexible Spending Account** \$ \_\_\_\_\_ (\$2,600 Maximum)  
**Dependent Care Account** \$ \_\_\_\_\_ (\$5,000 Maximum)  
**Medical/Dental Dues Account** \$ \_\_\_\_\_

*Section C Payroll Information*

**Name and address of Church Treasurer or person responsible for payroll:**

	Name
Treasurer's E-Mail Address	Church or Organization
Treasurer's Telephone Number	Street Address
	City State Zip Code

**Section D Qualifying Events and Required Documentation for Enrollment Changes during the Plan Year**

All Qualifying Events MUST be submitted with appropriate documentation in order to be processed. A new enrollment form must be completed and returned within 30 days after the Qualifying Event.

**HCFSA and Dependent Care Account Qualifying Events and Documentation**

- Marriage - Marriage Certificate
- Birth of a child - Birth Certificate
- Death of participant - Death Certificate
- Adoption of a child - Adoption agreement and employee's tax return showing eligible dependents.
- New employee - Letter from employer.
- Termination of employment - Letter from employer.

**Dependent Care FSA Only - Qualifying Events and Documentation**

- Divorce/legal separation/annulment - Divorce, annulment decree/separation agreement
- Death (spouse or dependent) - Death Certificate
- Change from FT or PT employment or vice versa - Letter from employer. (self, spouse)
- Approved unpaid leave of absence - Letter from employer. (self, spouse)
- Termination of employment - Letter from employer. (self, spouse)
- Reduction or increase of hours worked - Letter from employer (self, spouse).
- Ineligibility of dependent - Birth certificate or other appropriate documentation.

**Section E Authorization, Annual Salary Reduction Agreement and Certification**

I have read the plan document(s) governing the Health Care Flexible Spending Account (HCFSA), the Dependent Care Account (DeCap), and the Medical Dues Account. I understand that by submitting this Enrollment Form, I am making a binding election as to my benefit coverage for the Plan Year that begins January 1, 2015. I authorize my Employer to reduce my gross salary as indicated on this form in order to pay for the benefits I have elected. I understand that my payments will be pro-rated over each payroll period.

Note: I understand that my HCFSA election cannot be reduced or revoked for any reason except for termination of employment during the Plan Year. My HCFSA, DeCap or Medical Dues election can only be changed if I experience a Qualifying Event listed in Section D. I further understand that each account is separate and the DeCap funds cannot be used for or transferred to HCFSA or vice-versa. I understand that any amount remaining in the FSA that is not used during the Plan Year, will be forfeited, except for up to a \$500 carryover to the new Plan Year. I understand that I am only eligible to receive reimbursement on behalf of my eligible dependents listed on this form.

**Section F Employee/Participant Signature**

Signature

Date

/ /

Distribution: Church Treasurer or Person Responsible for Payroll  
Copy to Limited Third Party Claims Administrator -  
Joel Youkers  
[joel@maumeevp.org](mailto:joel@maumeevp.org)  
[419-785-4500](tel:419-785-4500)  
**Copy for your records.**