PREFERRED PG GROUP The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(866) 989-8995
Check out your Account Information Online
www.ThePreferredGroup.com

FSA Enrollment/Change Form

10042

Change Type:
☐ Address/Name Change
☐ New Hire
☐ Termination (Complete COBRA Form)
☐ Change in Status _____
☐ Unpaid Leave of Absence
☐ Return from Leave of Absence

Date of Event: ____/____/____

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information — Please Read, Complete & Return to the Payroll Office by September 14, 2012

Employer Group #	Employer Group Name	Plan Year	Social Security Number
10042	Cohoes CSD	10/1/2012 to 9/30/2013	___-___-___

Employee Name (First Name)	(Last Name)

Employee Address (Street, Apt. #)	Date of Birth (mm/dd/yyyy)	Date of Hire (mm/dd/yyyy)
	____/____/____	

Employee Address (City, State, Zip Code)	Current Debit Card Holder	Direct Deposit Account
,	Avail. See Addt'l Form	Avail. See Addt'l Form

Home Phone	Work Phone	Email Address (Please allow email from benefitsinfo@thepreferredgroup.com)

Section 2 Flexible Spending Plan Benefit Elections

___ I accept the opportunity to have deductions withheld from my paycheck for eligible employer sponsored ___Medical and other health insurance related premiums on a pretax (before tax) basis for my entire share of my employer's group health insurance premiums, unless I indicate below not to do so. I understand that this election will be automatically renewed each year unless revoked by me in writing prior to the beginning of a new Plan Year.

___ I waive (do not want) the opportunity to have my ___Medical insurance premium(s) withheld on a pretax (before tax) basis.

Account Type		Fund#	Prior Election	New Election		
UNREIMBURSED MEDICAL	($200 min/$2,500 max)	1	$0.00			
DEPENDENT DAY CARE	($5,000 max/$2,500 if married, filing separately)	2	$0.00			
PREMIUM EXPENSE	(For privately held health premiums only, no Life Ins.)	3	$0.00			

Section 3 Dependent Information

Social Sec. Num	Dependent Name	Address (Write 'same' for Employee Address)	Date of Birth	Spouse, Child, Other	Gender

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules

Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I cannot change any of my elections during the plan year (unless I have a change in status), and that any money left in my account(s) at the end of the plan year will be forfeited.

Employee Signature	Date

Section 5 Employer's Section — Payroll Information for Salary Reduction Changes

Payrolls

Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct
FSA				
DCA				
PRE				

Employer Signature	Date

Use 'First Payroll Date' and employer signature ONLY if the employee is making a *mid-year* election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an *old* election or termination.