P&A GROUP EST. 1975

Flexible Spending / Cafeteria Plan Enrollment Form

Employer name: Manatt's Inc.			Effective Date:
First Name: M.I. Last Name:			Employee #
Mailing Address:	City:	State:	Zip:
Social Security Number:	Phone Number:	Date of Birth:	Date of Hire:
E-mail Address:			

Account Type	Annual Election Amount	Office Use Only Amount/Pay Period
Health FSA (ie: Doctor co-payments, eye glasses) $2,700.00 annual maximum		
Dependent Care Assistance FSA $5,000 annual maximum		

Minimum reimbursement amount for manual check is $25

PLEASE NOTE: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION

I hereby elect the benefits indicated above. I have read and understand the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT_____**DATE** _____

Please return all enrollment forms to Human Resources

Revision 10/20/2017