WageWorks

2015 State of Ohio

SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Dependent Care Spending Account.

For Open Enrollment Only: You may enroll online at www.wageworks.com

DEPENDENT CARE

Name (Please Print) Last	First	MI	State of Ohio User ID #
Home Address Street	City	State	ZIP

Daytime Phone	Home Phone	Date of Hire	Date of Birth	Annual Salary
( )	( )			

E-mail Address

ENROLLMENT STATUS: ☐ OPEN ENROLLMENT ☐ RE-ENROLLMENT ☐ NEW HIRE ☐ CHANGE IN STATUS

CHANGE TYPE: _____ DATE: _____ / _____ / _____

- Indicate the amount you wish to pay through tax-free salary deduction completing the section below.
- For assistance, complete the Dependent Care Spending Account worksheets available at: **http://das.ohio.gov/flexiblespendingaccount.**
- If you have questions, consult your Flexible Spending Accounts Reference Guide, or call **Customer Service at 1.855.428.0446**.
- Your effective date will be the first of the month after receiving your enrollment form or January 1, 2015 if completed during open enrollment.

In Box #1, indicate the dollar amount you elect to contribute for the 2015 calendar year.

By signing this form you certify that you expect to receive payroll deductions to support your annual election amount. If necessary, decrease the election amount to allow for anticipated unpaid leave, planned retirement, mid-year enrollment, or any other anticipated leave.

DEPENDENT CARE SPENDING ACCOUNT

TAX FILING STATUS -PLEASE CHECK ONE:

Annual allowable minimum contribution per participant is $240.

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

Box #1 Total calendar year dollar deduction amount $ _____

To be eligible, you must be a permanent full-time or permanent part-time employee who has a qualified dependent. Enrollment must occur within 31 days of eligibility or during the open enrollment period. Deductions will be taken the first 24 pay periods of the calendar year unless you are paid monthly.

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before Medicare, local, state and federal income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that the funds in one Spending Account cannot be used to reimburse expenses covered by another Spending Account.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the calendar year or file an approved Change In Status Election Form with the contract administrator within 31 days of the event.
- I understand that the funds in any Spending Account can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand and agree that my employer and WageWorks, the contract administrator, will not incur any liability resulting from either my participation in any Spending Account or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming calendar year, unless otherwise provided by law.
- I certify that: 1) I will only use my Spending Account to pay for IRS-qualified expenses and only for 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 Spending Account, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE SIGNED

SUBMIT YOUR COMPLETED FORM TO P.O. BOX 1850, TALLAHASSEE, FL 32302-1850 OR FAX TO 1-866-672-4780.