Enrollment form

Cook County Flexible Spending Account Enrollment 2017

WageWorks® Health Care and Dependent Care Spending Accounts

WageWorks makes it easy to save on health care costs. For every $100 that you contribute to your pre-tax flexible spending account, you can save as much as $40 in taxes. The WageWorks' features, such as a convenient debit card, direct bill pay services, online account summaries, and monthly statements, ensure that you always know how much money you have.

ABOUT YOU *all fields are required; please print*

First name_____**Middle initial**____**Last name**_____

Home address_____ _____
Street *Apartment*

_____ _____ _____
City *State* *Zip*

Home phone ( )_____**Work phone** ( )_____**Date of Birth**_____**Hire Date**_____

Social security number_____-_____- _____ **Dept number**_____**Employee number**_____

HEALTH CARE SPENDING ACCOUNT

Tell us how much you'd like to contribute to your account for the 2017 plan year. Your contribution can be used for eligible medical, dental, and vision expenses not covered by your insurance plans and can be used for you and your eligible dependents.

Minimum contribution amount ..... **$250.00** per year
Maximum contribution amount ..... **$2,550.00** per year

Total annual contribution amount $_____

DEPENDENT CARE SPENDING ACCOUNT

Use your dependent care spending account to cover the costs of **day care, after-school programs, and daily elder care for your eligible dependents.** Eligible dependents include children 13 or younger and disabled parents and/or spouse.

Minimum contribution amount .....**$250.00** per year
Maximum contribution amount .....**$5,000.00** per year

Total annual contribution amount $_____

AUTHORIZATION

I have reviewed the enrollment materials for the Health Care and Dependent Care Spending Accounts. I understand that by signing and submitting this form that I am making a binding benefit election for this plan year and that I cannot change this election during the plan year unless I experience an eligible status change. I also understand that any amount remaining in my account that I do not use for eligible expenses incurred during my participation in the plan will be forfeited in accordance with the current tax law requirements. I authorize Cook County/Forest Preserve District to make the deduction from my salary for contributions as indicated above for my health care and/or dependent care spending accounts.

Signature_____**Date**_____

RETURN THIS FORM

By fax: (866)729-3040
Attention: FSA Administration

By mail: Department of Risk Management
Employee Benefits Office – FSA Administration
118 North Clark Street, Room 1072
Chicago, IL 60602-1304

QUESTIONS?

Please call Risk Management at (312) 603-6385 or call WageWorks toll free at (877) 924-3967

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For office use only