Consumer Driven Account Enrollment Form

OKLAHOMA COUNTY (Company Name) | **76-417044** (Group Number) | _____ (Location)

Social Security Number ☐☐☐-☐☐-☐☐☐☐

First Name _____ MI ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Gender _____ Marital Status _____ Date of Birth _____

Email Address _____ Phone Number _____

Date of Hire: _____

Flex Effective Date: _____

Payroll Schedule ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

	Contribution per Pay Period	Number of Pay Periods Remaining in Plan Year	Annual Election Amount
HEALTHCARE	$☐☐,☐☐☐.☐☐	X ☐☐	= ☐☐,☐☐☐.☐☐ **CANNOT EXCEED PLAN MAXIMUM OF $2,400.00**
DEPENDENT CARE	$☐,☐☐☐.☐☐	X ☐☐	= ☐,☐☐☐.☐☐ CANNOT EXCEED $5,000 PER HOUSEHOLD

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AUTHORIZATION: Please select your enrollment option below, then sign and date your form and submit to your benefit services department.

☐ I elect to participate in my employer's Consumer Driven Account Plan and agree to be bound by the terms of my employer's plan. I understand that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes. I understand that this agreement is only for eligible services and treatment provided during the Plan Year and that said services must be provided before the submission of claims for reimbursement. I also understand that I am making a binding election for the entire Plan Year unless I have a qualified change of status as defined by my employer's plan. Any salary deductions that have not been used for expenses incurred in the Current Plan Year may be forfeited depending on the terms of my employer's plan.

If the Plan Administrator determines that an expense, I submitted for reimbursement was not a qualified expense under the Plan Documents, I shall immediately reimburse the plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from wages or from otherwise valid expenses under the Plan to reimburse the unqualified expense.

☐ I decline enrollment in my employer's Consumer Driven Account Plan.

_____ _____

Employee Signature Date