HEALTH ECONOMICS GROUP, INC.

6901F

GENESEE COMMUNITY COLLEGE
FLEXIBLE BENEFITS PROGRAM
2023 ENROLLMENT FORM

EMPLOYEE INFORMATION (Please Print)

Employee Name:	Employee Social Security Number:		
Mailing Address:	**City:**	**State**	**Zip Code:**
Email Address:	**Phone:** ☐ Home ☐ Work ☐ Cell	**UNIT:** ☐ ESPA ☐ GEA ☐ MC	

Birth Date (Month / Day / Year)	Gender:	Marital Status:	PAYROLL USE ONLY	Employer Signature:
	☐ Male ☐ Female	☐ Single ☐ Married	Effective Date: ___ / ___ / _____ Pay Schedule: ☐ BC ☐ BP	

DEPENDENTS (Please PRINT clearly)

Name	Relationship	Birth Date
	spouse	
	☐ Daughter ☐ Son	
	☐ Daughter ☐ Son	
	☐ Daughter ☐ Son	
	☐ Daughter ☐ Son	

EMPLOYEE ELECTIONS

Benefit Election Options	Participation	Salary Reduction Amount		
Medical Expenses Maximum of **$3,050** per plan year.	YES ☐ NO ☐	$_____ per pay period	No. of pay periods during the Plan Year. **26**	$_____ per plan year
Dependent Care Expenses Maximum of **$5,000** per plan year. ($2,500 if married filing separately)	YES ☐ NO ☐	$_____ per pay period	No. of pay periods during the Plan Year. **26**	$_____ per plan year

NOTE: Amounts allocated to Health Care and/or Dependent Care are deducted on a pre-tax basis. New employees: if you enroll after the beginning of the Plan Year, pay period allocation amounts will be prorated according to the length of time remaining in the plan year. If an annual amount is not evenly divisible by the number of pay periods, the pay period amount will be rounded downward.
YOU MUST COMPLETE AND SUBMIT FEDERAL FORM W-10 FOR EACH CHILD CARE PROVIDER.

IMPORTANT: By enrolling in the Cafeteria/Flexible Benefits Program I understand that:

- I will be paid from the reallocation account(s) upon submission of properly prepared claim forms.
- I may not change my election during the Plan Year except for a change in family status.
- Dependent Care expenses will be reimbursed up to the balance funded through payroll deductions.
- I may not transfer money between options (Health and Dependent Care).
- I will forfeit any balance remaining 90 days after year end.

☐ **I elect to have my 2023 insurance premium contributions deducted on a pre-tax basis (by checking yes, I understand that I will not include premium amounts in my unreimbursed election).**

DIRECT DEPOSIT: ☐ NEW TO DIRECT DEPOSIT ☐ CHANGE OF BANK ACCOUNT ☐ ALREADY ON FILE WITH HEG

I wish to receive my plan payments by Direct Deposit. I hereby authorize Health Economics Group, Inc. (HEG) to originate electronic credit transactions to my bank (or credit union or savings & loan) account indicated below and to credit the same to such account. If necessary, HEG may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until HEG has received written notification from me of its termination in such time as to afford HEG and my bank a reasonable opportunity to act on it.

Bank Name:	Routing Number:

Account Type: Checking ☐ Savings ☐	Account Number:

Employee Signature: _____ **Date:** _____

(585) 241-9500 or (800) 666-6690 ext. 504