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mSAVE™ BENEFIT ACCOUNTS ENROLLMENT FORM.

EMPLOYEE INFORMATION:

Employer Name			
Employee Name (Last, First, MI)		Employee SSN	
Address		City, State, Zip	
Date of Birth	Phone #	Email Address	

BENEFIT OPTIONS:

Healthcare Flexible Spending Account (annual maximum $2,650)			
☐ I elect to participate. ☐ I elect NOT to participate.	$_____ Per Pay Period Deduction	_____ Pay Periods	$_____ Plan Year Election
Dependent Care Flexible Spending Account (annual maximum $5,000)			
☐ I elect to participate. ☐ I elect NOT to participate.	$_____ Per Pay Period Deduction	_____ Pay Periods	$_____ Plan Year Election
Limited Purpose FSA (annual maximum $2,650)			
☐ I elect to participate. ☐ I elect NOT to participate.	$_____ Per Pay Period Deduction	_____ Pay Periods	$_____ Plan Year Election
Parking (monthly maximum $260)			
☐ I elect to participate. ☐ I elect NOT to participate.	$_____ Per Pay Period Deduction	_____ Pay Periods	$_____ Plan Year Election
Transit (monthly maximum $260)			
☐ I elect to participate. ☐ I elect NOT to participate.	$_____ Per Pay Period Deduction	_____ Pay Periods	$_____ Plan Year Election
HSA (single annual maximum $3,500 & family annual maximum $7,000)			
☐ I elect to participate. ☐ I elect NOT to participate.	$_____ Per Pay Period Deduction	_____ Pay Periods	$_____ Plan Year Election

BENEFIT OPTIONS CONTINUED:

Deposit my reimbursements into my ☐ Checking or ☐ Savings account.

Bank Name:

Routing Number (9 digits):

Account Number:

Important:

- Incomplete or unsigned authorization forms cannot be processed.
- Reimbursements will appear in your bank account 1-2 days after the reimbursement date.

EMPLOYEE AUTHORIZATION:

I have received and read the enrollment materials. I understand that, by signing and submitting this form, I am making a binding benefit election under the flexible benefit plan for this plan year. I realize this election cannot be changed during the plan year unless I experience a qualified change in status. I also understand that any amount remaining in my account not used for eligible expense incurred during the plan year will be forfeited in accordance with current tax law requirements.

Employee Signature:	**Date:**

HR Use Only:	Effective Date:	First Deduction Date:

For assistance contact Maestro Health at:

questions@maestrohealth.com or 1.888.488.5054.