



EMPLOYEE ENROLLMENT FORM

Please be sure to send us this form, or turn it into the County Clerk's Office by _____

Company Name: **BAYFIELD COUNTY** Plan Year: 2021 Effective Date 01/01/2021

Please Print

Last Name: _____ First Name: _____ Middle Init.: _____

Address : _____ City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Hire _____ Date of Birth _____

E-mail: _____ Phone: _____

Spouse: _____ SS #: _____ - _____ - _____ Date of Birth ____/____/____

Dependant: _____ SS #: _____ - _____ - _____ Date of Birth ____/____/____

Dependant: _____ SS #: _____ - _____ - _____ Date of Birth ____/____/____

Dependant: _____ SS #: _____ - _____ - _____ Date of Birth ____/____/____

Dependant: _____ SS #: _____ - _____ - _____ Date of Birth ____/____/____

With regard to my election under this agreement, I understand that:

- Expenses for reimbursement must be incurred during the plan year, Which will include the grace period for the FSA
- Reimbursement requests must be accompanied by proof of eligible expense from the service provider or Insurance Company for an FSA, and an EOB (Explanation of Benefits) for an HRA.
- The reimbursement rate will be based on the plan design and may not be the entire amount requested.
- Prior to the first day of each plan year I will be notified of the contribution level for the next year.

Elections

Annual Contribution Level:

- Teamster \$5,350 HRA
- Courthouse \$2,000 Vested Dental/Vision HRA
- Medical FSA (annual maximum \$2,750) Per pay period \$ _____ x 24 = annual total \$ _____
- Dependant Care FSA (annual maximum \$5,000) Per pay period \$ _____ x 24 = annual total \$ _____

Waivers:

I acknowledge I have been informed of the terms of the **HRA** options. Even though I am eligible to participate in the plan, **I HEREBY ELECT NOT TO ENROLL**. This waiver will remain in effect for the remainder of this plan year; however, I may enroll in this plan year if I have a change in status.

I acknowledge I have been informed of the terms of the **FSA** options. Even though I am eligible to participate in the plan, **I HEREBY ELECT NOT TO ENROLL**. This waiver will remain in effect for the remainder of this plan year; however, I may enroll in this plan year if I have a change in status.

Signature: _____ Today's Date: _____