



# 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 \$2,700)

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 \$2,700)

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](mailto:questions@maestrohealth.com) or 1.888.488.5054.