CDH Enrollment Form
Section 125 Flexible Spending Account (FSA)

For expenses incurred AFTER the effective date of coverage and during the applicable Plan Year.
See your Summary Plan Description (SPD) for more information.

REHN & ASSOCIATES
Consumer Driven Healthcare (CDH) Department

ALL FIELDS REQUIRED

Enrollments received without required information will be sent back to your Employer so the missing data may be collected and may cause delays in enrollment process.

EMPLOYER DETAIL (Required – All Fields)

EMPLOYER NAME | **EFFECTIVE DATE**

PARTICIPANT DETAIL (Required – All Fields)

LAST NAME | **FIRST NAME** | **MIDDLE INITIAL**

SOCIAL SECURITY NUMBER (XXX-XX-XXXX) | **DATE OF BIRTH** | **MOTHER'S MAIDEN NAME**

MAILING ADDRESS | **CITY** | **STATE** | **ZIP CODE**

+1(XXX) XXX-XXXX
PHONE NUMBER | **EMAIL ADDRESS**

BENEFIT ELECTION OPTIONS (Required – FSA Election(s) and Annual Amount)

☐ **MEDICAL FSA (MFSA)**
All eligible IRS 213(d) Medical, Dental, Vision and Prescription Expenses for you and your eligible dependents.

$ 0.00
MFSA ANNUAL ELECTION AMOUNT

☐ **DEPENDENT CARE FSA (DFSA)**
Child Care Expenses for children under age 13 or for a person whom you claim as a dependent on your federal income tax return and who is mentally or physically incapable of caring for themselves.

$ 0.00
DFSA ANNUAL ELECTION AMOUNT

If the Annual Election amount chosen above is greater than the Employer's Maximum Annual Election Amount, you will be enrolled at the Employer's Maximum Annual Election Amount by default. If the Annual Election amount chosen is less than the Employer Minimum Annual Election Amount, the form will be returned to the Employer for correction.

******Please visit CDH.rehnonline.com to ADD or CHANGE direct deposit information.******

I understand that the rules and regulations of IRC Section 125 allow an employee to redirect a portion of their salary, through payroll deduction, into the designated qualified benefits listed above on a pre-tax basis. By completing and signing this form, I hereby elect to participate in the Employer's Medical and/or Dependent Care Flexible Benefits Plan for the Plan Year associate with the Effective Date provided above. I have read and understand the descriptive material covering the Medical and Dependent Care Reimbursement Components as stated in the Summary Plan Description. I understand that this enrollment form will remain in effect and cannot be revoked or changed during the Plan Year unless the revocation and new election are on account of and consistent with a change in status event. Further, my election on this enrollment form revokes any prior election relating to the same matter under the Plan. My participation in the Plan terminates on the last day of the Plan Year or upon termination, whichever is earliest. I also understand that being offered this benefit, Rehn & Associates or the Employer has provided no tax advice to me regarding participation in this plan; therefore, I agree to hold Rehn & Associates and/or the Employer harmless for any future taxes or penalties that may be imposed by the Internal Revenue Service due to future interpretations or changes in the laws governing the flexible benefits plan. I authorize and direct my Employer to reduce my salary in the amount necessary to pay for the benefits shown above and I understand that any amounts left in my reimbursement account after all claims have been paid at the end of the Plan Year will be forfeited. I authorize Rehn & Associates to initiate reimbursements via direct deposit as stated.

EMPLOYEE SIGNATURE | **DATE** (MM/DD/YYYY)

Rehn & Associates Consumer Driven Healthcare (CDH) Department
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