STATE OF NEW MEXICO ENROLLMENT FORM

HEALTHCARE AND/OR DEPENDENT CARE FLEXIBLE SPENDING

BENEFITS ADMINISTERED BY ERISA TRUST

GENERAL INFORMATION:

Employee Name: _____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____ Branch/Agency:_____

E-mail address:_____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

Date of Hire (MM/DD/YYYY): _____ Employee ID:_____

Healthcare FSA

- **The Healthcare FSA can be used to reimburse your out-of-pocket responsibility for medical, dental, vision care, and prescription expenses for the employee and eligible dependents. Domestic partner and Domestic partner children expenses are not eligible under the FSA Health Care Program.**

	Per Pay Period	# Pay Periods		Annual Election
Healthcare: **The minimum annual election per participant is $130.00, the maximum annual election is $2750.00**	$_____	x _____	=	$_____

Dependent Care FSA

- **The Dependent Care FSA can be used to reimburse your out of pocket expenses to dependent care providers who provide services to your dependent children or disabled dependents in order to allow you to work.Domestic partner children expenses are not eligible under the FSA Dependent Care Program.**

	Per Pay Period	# Pay Periods		Annual Election
Dependent care: **$5,000 annual household maximum election**	$_____	x _____	=	$_____

Enrollment in both categories in this section will terminate at the end of each calendar year unless you re-enroll for the following year.

AUTHORIZATION & ACKNOWLEDGEMENT:

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverage show above in accordance with the State of New Mexico Flexible Spending Plan, Section 125. Such reductions, considered as elective contributions under the plan, shall commence within the payroll cycle in which this election is received by my payroll center.

Once elected Flexible Spending benefits can only be modified or revoked if you undergo a Qualifying Event. Please see your HR representative for details.

I understand that after the Grace Period any unused money may not be refunded, nor may it be carried over to subsequent periods in accordance with current plan provisions and tax laws.

I understand that if requested, I must submit documentation to substantiate claims and/or debit card charges. I certify that I will only submit claims for reimbursement under the Flexible Spending Account for eligible expenses incurred by myself and/or eligible dependents in accordance with the terms of the Flexible Spending plan.

Date _____

*If you are a new hire, your election in the plan is not immediate. Once you've submitted your enrollment form, please contact Erisa to determine when your deductions will begin.