The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(866) 989-8995

Your Account Information Is Online
www.ThePreferredGroup.com

WLT10089

Greenwich CSD
PG Blue - FSA Enrollment Form

— Please Read, Fill Out Carefully & Return to Payroll

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information

Employer Group #	Employer Group Name	Plan Year	Social Security Number
10089	**Greenwich CSD**	**1/1/2021** to **12/31/2021**	_____-____-_____

Employee Name (First Name) | (Last Name)

Employee Address (Street, Apt. #) | Date of Birth (mm/dd/yyyy) ____/____/_____

Employee Address (City, State, Zip Code)
,

Home Phone | Cell Phone | Email Address (Please allow email from benefitsinfo@thepreferredgroup.com)

Section 2 Flexible Spending Plan Benefit Elections

___ I accept the opportunity to have deductions withheld from my paycheck for eligible employer sponsored medical, dental, vision, and other health insurance related premiums, including ___Personal Cancer Indemnity Plan, on a pretax (before tax) basis for my entire share of my employer's group health insurance premiums, unless I indicate below not to do so. I understand that this election will be automatically renewed each year unless revoked by me in writing prior to the beginning of a new Plan Year.
___ I waive (do not want) the opportunity to have my insurance premium(s), including ___ Personal Cancer Indemnity Plan withheld on a pretax (before tax) basis.

Account Type		Fund#		New Election		
MEDICAL FSA	(GTA $2,750 max/ CSEA & Admin Conf. $2,750 max)	1				
DEPENDENT DAY CARE	($5,000 max/$2,500 if married, filing separately)	2				

Section 3 Reimbursement Options

If you wish to have your reimbursements directly deposited to your bank account, please fill in the line below.

Direct Deposit Setup: Bank Name_____ Routing #_____ Acct #_____

Initial to Request Debit Card _____

Please note: By entering the above information you are enrolling into these specified programs and are validating your dependent information. For more information on these options including the timing of reimbursements, please see your Summary Plan Description.

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules

Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I am only entitled to the amount of the above elections and cannot change any of my elections during the plan year (unless I have an acceptable change in status), and that any money left in my account(s) at the end of the plan year will be treated in accordance with my employer's FSA plan document.

Employee Signature | Date

Section 5 Employer's Section — Payroll Information for Salary Reduction Changes

Payrolls

Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct
FSA				
DCA				

Employer Signature | Date

Use 'First Payroll Date' and employer signature ONLY if the employee is making a *mid-year* election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an *old* election or termination.