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

Your Account Information Is Online
www.MyTPGPlan.com

LH110037

CEWW BOCES
PG Plus - FSA Enrollment Form

— Please Read, Complete & Return to Payroll Office by September 10, 2021

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
10037	**CEWW BOCES**	**10/1/2021** to **9/30/2022**	______-____-______

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 insurance related premiums 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 waive (do not want) the opportunity to have my medical insurance premium(s) withheld on a pretax (before tax) basis.

Account Type		Fund#		New Election		
MEDICAL FSA	($300 min/$2,750 max)	1				
DEPENDENT DAY CARE	($5,000 max/$2,500 if married, filing separately)	2				
PREMIUM EXPENSE	(For privately held dental/vision premiums only, no Life Ins.)	3				

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 #____________________

New Enrollees will receive a direct mailed 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 spending 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: 18

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

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.

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