Mail to: P.O. Box 14766, Lexington KY 40512-4766

STATE OF NEW JERSEY
PLAN YEAR 1/1/2016–12/31/2016

Enrollment/Change In Status Form

HOW TO ENROLL IN THE FLEXIBLE BENEFITS PLAN:
Indicate any benefits in which you want to participate by completing Section 3 below. Enter the corresponding annual election amount of the benefits you have chosen.

RETURN YOUR COMPLETED ENROLLMENT FORM TO WageWorks at above address or fax to 1-866-672-4780. Questions? Call Customer Service at 1-855-428-0446.

FLEXIBLE BENEFITS

Indicate all selections by entering the necessary information below. You must enter a dollar amount to receive the corresponding benefit.

1

SELECT YOUR EMPLOYER AGENCY BELOW:

☐ State Agency (Centralized Payroll)

☐ The Legislative Group (CS26)

☐ Palisades Interstate Park Commission (00330)

☐ Rowan University (00410)

☐ New Jersey City University (00411)

☐ New Jersey Institute of Technology (02700)

☐ Rutgers University - formerly UMDNJ employees (00497)

☐ Rutgers University (00910)

☐ New Jersey Building Authority (90090)

☐ University Hospital (00498)

2

INSTRUCTIONS

3

FLEXIBLE BENEFITS

☐ I wish to enroll in the MEDICAL EXPENSE PLAN BENEFITS

For uninsured eligible medical/dental/vision expenses incurred by you, your family members, or both. (Minimum contribution is $100 per year; maximum allowable contribution is $2,500 annually.)

Total Plan Year Dollar amount. $________________

THIS IS YOUR ANNUAL TAX-FREE SALARY DEDUCTION AMOUNT

☐ I wish to enroll in the DEPENDENT CARE PLAN BENEFITS*

☐ Married, filing separately

☐ Married, filing jointly

☐ Single, head of household

TAX FILING STATUS [PLEASE CHECK ONE]:

Total Plan Year Dollar amount (minimum $250 per year). $________________

THIS IS YOUR ANNUAL TAX-FREE SALARY DEDUCTION AMOUNT

4

☐ I elect to change my Annual Salary Deduction Amount from $___________ to $___________ for the Unreimbursed Medical Spending Account due to a Change in Family Status.

☐ I elect to change my Annual Salary Deduction Amount from $___________ to $___________ for the Dependent Care Spending Account due to a Change in Family Status.

CHANGE IN FAMILY STATUS

CHANGE - Please complete the following:

☐ Significant change in health coverage due to spouse’s employment

☐ Change in cost or coverage of Dependent Care

☐ Death of dependent

☐ Change in work status of spouse

☐ Birth or legal adoption of child

☐ Marriage

☐ Divorce

☐ Significant change in health coverage due to spouse’s employment

DATES

DATE EMPLOYED

DATE OF CHANGE IN FAMILY STATUS

REQUESTED BY:

EMPLOYEE SIGNATURE

DATE SIGNED

3967-WW-EF-NJ (08/2015)