



FLEXIBLE BENEFITS ENROLLMENT FORM



cis benefits
www.cisbenefits.org

1/1/2022 - 12/31/2022 Plan Year

COMPLETE THIS FORM AND RETURN TO YOUR
BENEFITS REPRESENTATIVE

Entity Name: _____

PART 1 – EMPLOYEE DATA

EMPLOYEE NAME (LAST, FIRST, MI.)		SOCIAL SECURITY NUMBER	
HOME ADDRESS (INCLUDE APARTMENT NUMBER)			
CITY	STATE	ZIP	
DATE OF BIRTH	DATE OF HIRE		

PART 2 – ELECTIONS

Healthcare Flexible Spending Account

(Calendar year maximum is \$2,750)

- ☐ I elect to contribute \$ _____ per pay period x _____ remaining pay periods = \$ _____ Plan Year Total
- ☐ I elect to waive coverage.

Dependent Care Flexible Spending Account

(Calendar year maximum is \$5,000 for married filing jointly or single, or \$2,500 if married filing separately.)

- ☐ I elect to contribute \$ _____ per pay period x _____ remaining pay periods = \$ _____ Plan Year Total
- ☐ I elect to waive coverage.

PART 3 – AUTHORIZATION

I have reviewed the terms of CIS' Flexible Benefits Plan. I understand that I may elect coverage under any or all of the above components, if offered. I understand that contributions will be deducted from my compensation on a pre-tax basis and the deductions cannot be changed until the next plan year unless I experience a qualified status change. I have read and agree to the terms of participation.

EMPLOYEE'S SIGNATURE _____

DATE _____

FOR EMPLOYER USE ONLY:

COMPANY NAME	DIVISION	EFFECTIVE DATE	PAY CYCLE	ENTERED IN PAYROLL	INITIAL:
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