ENROLLMENT/CHANGE FORM

HR SIMPLIFIED

EMPLOYER NAME: Rockford Area Schools

Plan Year: **January 1, 2021 - December 31, 2021**

Enrollment (Check one): ☐Open Enrollment ☐ New Hire ☐Qualifying Event (Please provide) _____

EMPLOYEE INFORMATION --- PLEASE PRINT CLEARLY

Name:		Employee SSN Number:
Mailing Address:		
City:	State:	Zip Code:
Phone Number:	Cell Phone:	Date of Birth:
Email Address:	Gender: ☐Male ☐ Female	Marital Status: ☐Married ☐ Single
Preferred Reimbursement: ☐Check ☐ ACH	I Elect a Debit Card (New card is not issued if you already have one): XX Yes, please issue ☐Yes, currently have a card ☐No	

****Direct Deposit Sign Up – Read Carefully**

- By completing this section, you are requesting HR Simplified, Inc. to initiate Direct Deposit for all manual claims.

NAME OF BANK: _____ ☐Checking
ACCOUNT NUMBER: _____ ☐Savings
ROUTING NUMBER: _____

I authorize HR Simplified, Inc. to initiate credit entries and, if necessary, to initiate any debit entries to correct an erroneous credit entry to my account at the DEPOSITORY (identified above), for the purpose of automatically depositing funds to my account. I acknowledge that the origination of these transactions must comply with the provisions of U.S. Law.

I understand that this authorization replaces any previous authorization and will remain in full force and effect until HR Simplified, Inc. has received written notification from me of its termination in such time and in such manner as to afford the HR Simplified., Inc. and the DEPOSITORY a reasonable opportunity to act on it.

SIGNATURE: _____ **DATE:** _____

PLAN DESCRIPTION -- PLEASE READ CAREFULLY	Enroll	Payroll Amount	Election Amount	
Health Care Reimbursement Account (FSA) Includes all eligible health care expenses. Subject to annual maximum of $2,750. Does not require participation in employer's health insurance plan.	☐Yes ☐ No	$_____	$_____	☐ I elect to waive all pre-tax benefits under the Flexible Benefit Plan. Except for a Change in Status, I understand that I cannot elect pre-tax benefits until the next Anniversary Date and any after-tax coverage shall be outside the Plan.
Dependent Care Reimbursement Account (DCA)*** **********Child is no longer eligible at age 13************ Includes all eligible dependent care expenses. Subject to annual IRS maximum of $5,000 per Head of Household or married couple filing jointly.	☐Yes ☐ No	$_____	$_____	
Health Savings Account Single maximum - $3,600; Family maximum - $7,200, 55 and over catch up $1,000 – ER contribution, if any, must be included.	☐Yes ☐ No	$_____	$_____	
Limited Purpose Health Care Reimbursement Account (HSA Compatible FSA) Covers only vision, dental, and medical expenses after your medical deductible has been met. Subject to annual maximum of $2,750.	☐Yes ☐ No	$_____	$_____	

DEPENDENT INFORMATION **(Please check a box in the Release of Information & Debit Card -- without your consent HR Simplified will not issue a card or release any information regarding your account to any dependent).**

Name	SSN	Date of Birth	Relationship	Release of Information**	Debit Card (18 years+)**
				☐Yes ☐ No	☐Yes ☐ No
				☐Yes ☐ No	☐Yes ☐ No
				☐Yes ☐ No	☐Yes ☐ No

ADDITIONAL HSA INFO:	Driver's License #:	US Citizen? ☐Yes ☐ No:	Mother's maiden name:	**Please fill out a Beneficiary form if other than spouse**	

PARTICPANT SIGNATURE

Employee's Signature:	Date:

TO BE COMPLETED BY EMPLOYER ONLY:

Effective Date:	Total pay dates remaining in the plan year:	First Payroll:	Employee Highly Compensated:	Employee Division:
Employer Signature:			Date:	Comments:

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