

HEALTHY DOLLARS

DCA ENROLLMENT / CHANGE FORM

ENROLLMENT CHANGE TERMINATION EMPLOYER: _____

First Name:		Last Name:	
Social Security Number:		Date of Birth:	
Phone Number	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Email:	
Effective Date:		Address:	

ELIGIBILITY:

Do you have an HSA?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you contributing to it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare Beneficiary?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Medicare ID	
Health Plan Information Please indicate the health plan you are on:	<input type="checkbox"/> Company Sponsored Plan <input type="checkbox"/> Spousal/Partner Plan	<input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medicare <input type="checkbox"/> Ind. VHC

DEPENDENT INFORMATION:

Last Name	First Name	SS #:	Date of Birth	Please choose where covered & note if different for each
				<input type="checkbox"/> Company Sponsored Plan <input type="checkbox"/> Medicaid
				<input type="checkbox"/> Spousal/Partner Plan <input type="checkbox"/> Medicare
				<input type="checkbox"/> Other: _____ <input type="checkbox"/> Ind. VHC

ELECTION:

Dependent Care Account	Annual Election	Deduction Per Pay Period	# of Pay Periods

Authorization I hereby elect to participate in my employer's DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at any time through the plan year. I also agree that if I cannot produce a copy of the requested receipt, the transaction will be deemed ineligible and I will be required to refund the plan for the total expenses. I

ELECT to participate in the Healthy Dollars Plan I **DO NOT** elect to participate in the Healthy Dollars Plan

Employee Signature: _____ Date: _____

*** For Accurate Enrollment Please Write Clearly ***

October 2016