NJ Tax$ave
Horizon *MyWay*®
FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Complete and return to Horizon

Group Information

Group Name: STATE OF NEW JERSEY **Horizon Group Number:** 601050

Employer Agency: ☐ Centralized Payroll (0001) ☐ Legislative Group (0002) ☐ Rutgers State University (1229)
☐ NJIT - New Jersey Institute of Technology (1285) ☐ Ramapo College (1812) ☐ College of New Jersey (1820)
☐ Thomas Edison State University (1821) ☐ Stockton University (1822) ☐ New Jersey City University (1823)
☐ WM Patterson University (1824) ☐ Rowan University (1825) ☐ Montclair University (1826) ☐ Kean University (1832)
☐ New Jersey Building Authority (8005) ☐ UNH - University Hospital (8157) ☐ Palisade Interstate Park Commission (9910)

Employee Information

SSN#: ____________________ **Primary Phone:** ____________________

Last Name: ____________________ **First Name:** ____________________ **Middle Initial:** ______

Street Address: ____

City: ____________________ **State:** ________ **ZIP Code:** ____________

Email Address: ____________________ **Date of Birth:** ______ / ______ /________

Pay Cycle: ☐ 10 Months ☐ 12 months

Account Information

Medical Flexible Spending Account:

Plan year maximum $2,500.00 (not to exceed $2500 maximum)

Effective Date: ____________________ **Hire Date (Only Applicable for New Hires):** ____________________

☐ I want to contribute a total of $__________ (minimum $100.00) during this plan year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Note: If you or your spouse are enrolled in a Health Savings Account (HSA), you are not eligible to enroll in the Medical Flexible Spending Account.

Dependent Care Flexible Spending Account:

Eligible expenses for the Dependent Care Plan include the care of eligible dependents in order for the parent to work. This includes day care centers, private baby sitters, nursery schools, etc., Dependent Care Plan is not for medical care. Children are no longer eligible upon reaching age 13.
IRS Maximum: $5000.00 ($2500 if married but filing separate tax returns)

Effective Date: ____________________ **Hire Date (Only Applicable for New Hires):** ____________________

☐ I want to contribute a total of $__________ (minimum $250.00) during this plan year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Signature

I have reviewed the above elections and understand my choices will remain in effect for the entire Plan Year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my accounts at the end of the Plan Year may be forfeited.

Signature: ____ **Date:** ____________

Send via secured email only:
HorizonMyWay.Documents@HelloFurther.com

Fax to:
866-231-0214

Mail to:
PO Box 982814
El Paso, TX 79998-2814

An Independent Licensee of the Blue Cross and Blue Shield Association.