maestro health™

maestroEDGE Benefit Accounts Enrollment Form

EMPLOYEE INFORMATION: (Please print clearly)		
Employer Name **Union County**		
Name (Last, First, MI)		Employee SSN
Address		City, State, Zip
Date of Birth	Phone Number	Email Address
Payroll Schedule **Bi-weekly**		First Deduction Date **07/09/2020**

BENEFIT OPTIONS	BENEFIT ELECTION
HEALTHCARE FLEXIBLE SPENDING ACCOUNT (Max: $2,750)	
☐ I elect to participate. ☐ I elect NOT to participate.	$ _____ Annual Election
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (Max: $5,000)	
☐ I elect to participate. ☐ I elect NOT to participate.	$ _____ Annual Election

Yes! Deposit my reimbursements into my ☐ Checking or ☐ Savings account.

Bank Name _____

Routing Number (9 digits): _____ Account Number: _____

Important:

- Incomplete or unsigned authorization forms cannot be processed.
- Reimbursements will appear in your bank account 1-2 days after the reimbursement date.

For assistance contact Maestro Health at questions@maestrohealth.com or 1-888-488-5054

EMPLOYEE AUTHORIZATION:

I have received and read the enrollment materials. I understand that, by signing and submitting this form, I am making a binding benefit election under the flexible benefit plan for this plan year. I realize this election cannot be changed during the plan year unless I experience a qualified change in status. I also understand that any amount remaining in my account not used for eligible expense incurred during the plan year will be forfeited in accordance with current tax law requirements.

_____ _____

Employee Signature Date