maestro health™

maestroEDGE Benefit Accounts Enrollment Form

EMPLOYEE INFORMATION: (Please print clearly)		
Employer Name		
Name (Last, First, MI)		Employee SSN
Address		City, State, Zip
Date of Birth	Phone Number	Email Address
Payroll Schedule		First Deduction Date

BENEFIT OPTIONS			BENEFIT ELECTION
HEALTHCARE FLEXIBLE SPENDING ACCOUNT			
☐ I elect to participate. ☐ I elect NOT to participate.	$ _____ Per Pay Period Deduction	26 Pay Periods Remaining	$ ☐☐☐,☐☐☐ Annual Election
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT			
☐ I elect to participate. ☐ I elect NOT to participate.	$ _____ Per Pay Period Deduction	26 Pay Periods Remaining	$ ☐☐☐,☐☐☐ 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