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 _____(not to exceed $2500 maximum)

Effective Date: _____

☐ 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.

Are you or your spouse actively contributing to a Health Savings Account?

☐ No

☐ Yes: Your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met.

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: _____

☐ 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:
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El Paso, TX 79998-2814