NJTRANSIT The Way To Go.®

FLEXIBLE SPENDING ACCOUNTS (FSA) ENROLLMENT FORM

Company Payroll: ❑ Bus ❑HQ ❑ Rail ❑ Union ❑ Non-Union	Employee #:	Effective Date: **01/01/2020**
Check One: ❑ **Open Enrollment for 2020**		
Name (Last, First, M.I.)	Birthdate	Sex ❑ M ❑ F
Address (No., Street, City, State and Zip Code)		
Email Address:	Phone #:	

I hereby authorize NJ TRANSIT Corporation to reduce my earnings for the Plan Year for deposit into my Flexible Spending Account(s), and to make this money available to me for reimbursement of my eligible out-of-pocket healthcare expenses or eligible dependent care expenses, in the amounts indicated below. I understand that I will forfeit any unused balance in my account(s) beyond the allowed carryover* at the end of the Plan Year. I also understand that I cannot change my plan participation unless I have a change in family status, as defined by Internal Revenue Code Section 125.

HEALTHCARE FSA (Minimum Annual Contribution $240; Maximum-refer to Annual Open Enrollment Memo)

Annual Election Amount $ _____

I have waived participation in NJ TRANSIT's Healthcare Plan. Check one: ❑ yes ❑ no

DEPENDENT CARE (Minimum Annual Contribution $240; Maximum-refer to Annual Open Enrollment Memo)

Annual Election Amount $ _____

Signature_____ **Date:** _____

I understand the following: This election form will remain in effect and cannot be revoked or changed during the Plan Year unless revocation and new election are on account of and consistent with a change in family status (e.g. legal divorce or marriage; birth or legal adoption of a child; death of a dependent; change in work status for you or your spouse; or change in cost or coverage for Dependent Care).

***Carry over only applies to the Healthcare FSA**

NOTE: Your salary reduction is made on a pre-tax basis, in accordance with the IRC Section 125 guidelines, and is subject to IRC nondiscrimination testing and contribution refund requirements.