2023 Return from LOA

Enrollment form

Cook County Flexible Spending Account Enrollment 2023

Healthcare and Dependent Day Care Spending Accounts

Please note that annual contribution amounts elected outside of Open Enrollment will be spread over the remaining pay periods in the plan year.

Employee Information: All fields are required; please print clearly.

Social Security # _____ **Last Name** _____ **First Name** _____ **MI** ____

Address _____ **Apt #** _____ **City/State**_____ **Zip Code** _____

Home/Cell phone ( ) _____ **Work phone** ( ) _____

Employee number _____ **Hire Date** _____

HEALTHCARE SPENDING ACCOUNT

Indicate how much you'd like to contribute to your account for the 2023 plan year. Your contribution can be used for eligible medical, dental, and vision expenses not covered by insurance plans and can be used for you and your eligible dependents health expenses.

Minimum contribution amount ..... **$250.00** per year
Maximum contribution amount ..... **$2,850.00** per year **Total annual contribution amount $**_____

DEPENDENT DAY CARE SPENDING ACCOUNT

Use your dependent care spending account to cover the costs of **day care, after-school programs, and daily elder care for your eligible dependents.** Eligible dependents include children 13 or younger and disabled parents and/or spouse.

Minimum contribution amount .....**$250.00** per year
Maximum contribution amount .....**$5,000.00** per year **Total annual contribution amount** $_____

AUTHORIZATION

I have reviewed the enrollment materials for the Healthcare and Dependent Care Spending Accounts. I understand that by signing and submitting this form that I am making a binding benefit election for this plan year and that I cannot change this election during the plan year unless I experience a Qualifying Life Event. I also understand that any amount remaining in my account that I do not use for eligible expenses incurred during my participation in the plan year will be forfeited in accordance with the current tax law requirements. I authorize Cook County/Forest Preserves of Cook County to make the deduction from my salary for contributions as indicated above for my healthcare and/or dependent care spending accounts.

Signature _____ **Date** _____

RETURN THIS FORM

Fax: (866) 729-3040

Email: risk.mgmt@cookcountyil.gov

By mail: Department of Risk Management
Employee Benefits Division
118 North Clark Street, Room 1072
Chicago, IL 60602-1304

QUESTIONS?

Please call Risk Management at (312) 603-6385.