



mSAVE 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 #

Email Address

BENEFIT OPTIONS

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (maximum \$2,700)

- I elect to participate.
I elect NOT to participate.

\$ Per Pay Period Deduction

Pay Periods

\$ Plan Year Election

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (maximum \$5,000)

- I elect to participate.
I elect NOT to participate.

\$ Per Pay Period Deduction

Pay Periods

\$ Plan Year 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

HR Use Only:

Effective date:

First deduction date: