Flexible Benefits Enrollment and Change Form

☐ Annual Enrollment ☐ New Hire ☐ Eligibility Change – Only for Dependent Care Accounts (change of: work shift, provider, provider cost)

☐ Status Change/Description_____ _____ Date of Change_____

Cobb County Government
100 Cherokee Street
Marietta, Ga. 30090-7006
770 528-2541; fax: 770-528-2550

Section A - Employee/Employer Information

Company/Employer **COBB COUNTY GOVERNMENT**	Plan Effective Date	Enrollment Effective Date
Employee Name Last Name First Name Middle Initial		Social Security Number
Mailing Address Street/P.O. Number City State ZIP		Date of Birth:
Pay Period ☐ Bi-weekly		Date of Hire:

Section B - Enrollment in Flexible Spending Accounts

Please check each plan in which you want to participate, and enter the amount you request to be deducted from your pay for each Account.

☐	Deduction Per Pay Period	Annual Deduction	**Complete If Electing Not To Participate**
☐ Medical FSA	$	$	☐ I do not wish to participate
☐ Dependent Care FSA	$	$	☐ I do not wish to participate

If you enrolled in the **Dependent Care Flexible Spending Account**, ☐ please enter information about your spouse, if any.

Spouse Name: Last First MI	/ / Date of Birth	Social Security No.	Spouse is ☐ Employed ☐ Disabled

Section D – Enrollment Election (Signature required whether electing or waiving coverage)

I hereby authorize my employer to make pre-tax payroll deductions from my salary, per pay day, in the amounts I have written in above for the Flexible Spending Accounts I have elected to participate in. Additionally, I agree and understand that I can not change or revoke the above amounts except during the Plan's Annual Open Enrollment Period. However, with my employer's approval I may be authorized to make a change in my election if I experience a change in status as specified in the Flexible Benefit Plan Document. If I am the recipient of the MBI MasterCard®. I hereby agree to abide by the terms of the Employee Disclosure Statement accompanying the Card.

If I have waived enrollment in any of the above plans, I understand that I will not have another opportunity to enroll until the next open enrollment period which begins in November and changes will be effective the 1st of the following year.

Signature Confirming Election **Date**

Please return this form to Cobb County Human Resources

Cobb County Employer Authorization **Date**

SPCARD
Initial