

**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