



ERA Enrollment Form PLAN YEAR 20__

State of Wisconsin Employee Reimbursement Account Program

Complete this enrollment form if you wish to establish or continue a tax-free reimbursement account. (Press hard with ball point pen. Do not use carbon paper.)

Administered for the State of Wisconsin, Department of Employee Trust Funds by:



Form with fields for Social Security #, Employer, Last Name, First Name, MI, Home Address, City, State, ZIP, Work Phone, Home Phone, E-mail, and ENROLLMENT STATUS (NEWLY HIRED or OPEN ENROLLMENT).

Check here if you are sending in a separate Rapid Refund form. Current Rapid Refund participants do not need to submit another form.

REIMBURSEMENT ACCOUNTS

Table with columns for MEDICAL EXPENSE ACCOUNT and DEPENDENT CARE ACCOUNT, including fields for Amount, Total Plan Year Dollar Amount, Number of Paycheck Contributions, and Reduction Per Regular Paycheck.

TERMS AND CONDITIONS

IMPORTANT

- List of important terms and conditions regarding salary reduction, reimbursement, and coverage.

Employee Signature X _____ Date Signed _____

For office use only:

Received Date _____ Payroll Center _____ Agency Code _____
Paycheck Frequency _____ Paycheck Effective Date _____ Coverage Effective Date _____ Payroll Authorization _____

FBMC USE ONLY

Table with 5 columns: DATA ENTRY, VERIFICATION, SCANNED, INDEXED, SPECIAL NOTES