NJ Tax$ave
Horizon *MyWay*®
FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Complete and return to Horizon

Tax$ave is available to State employees who are eligible to participate in State Health Benefits Program (SHBP). Both Horizon and Aetna utilize this Horizon Tax$ave FSA enrollment form.

Group Information

Group Name: STATE OF NEW JERSEY **Employer Agency:** ☐ **Centralized Payroll (000100)**

☐ **Legislative Group (000200)** ☐ **Rutgers State University (122900)** ☐ **NJIT - New Jersey Institute of Technology (128500)**

☐ **Ramapo College (181200)** ☐ **College of New Jersey (182000)** ☐ **Thomas Edison State University (182100)**

☐ **Stockton University (182200)** ☐ **New Jersey City University (182300)** ☐ **WM Paterson University (182400)**

☐ **Rowan University (182500)** ☐ **Montclair University (182600)** ☐ **Kean University (183200)**

☐ **New Jersey Building Authority (800500)** ☐ **UNH - University Hospital (815700)** ☐ **Palisade Interstate Park Commission (991000)**

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** **Date of Hire:** _____

Accounts Available For Enrollment

1. Medical Flexible Spending Account:

Plan year maximum $2,500

Effective Date: _____ (1/1/20XX if enrolling during Open Enrollment Period)

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.

Note: If you or your spouse are enrolled in a Health Savings Account (HSA), you are not eligible to enroll in the Medical Flexible Spending Account.

2. Dependent Care Flexible Spending Account:

Plan year maximum $5,000

Effective Date: _____(1/1/20XX if enrolling during Open Enrollment Period)

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.

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)

Note: In order to comply with IRS non-discrimination testing requirements for the entire plan, contributions of highly compensated individuals (currently set by the IRS as earning $165,000 or more) may be adjusted downward by the State during Plan Year 2026 to meet IRS requirements.

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@healthaccountservices.com

Fax to:
833-710-5544

Mail to:
PO Box 2340
Fargo, ND 58108-2340

An Independent Licensee of the Blue Cross and Blue Shield Association.