



**NEW YORK STATE
ADOPTION ADVANTAGE ACCOUNT ENROLLMENT FORM**

January 1, 2019 – December 31, 2019

GENERAL INFORMATION

Employee Name _____

Mailing Address _____

City, State, Zip _____

Email Address _____

NYS Employee ID _____ Date of Birth (MM/DD) _____

Department ID _____ Bargaining Unit Number _____

ADOPTION ADVANTAGE ACCOUNT

I hereby elect to participate in the Adoption Advantage Account

Annual Election: \$ _____ Accelerated Payroll End Date: _____

Stop my participation due to the termination of adoption proceeding.

<i>Goer Administrative Office Only</i>	Per Pay Period	# Pay Periods	Annual Election
Adoption Advantage Account	\$ _____	X _____	= \$ _____
Effective date of coverage: _____ The first payroll deduction will be on: _____, 20_____			
Date of hire: _____ Pay schedule is: <input type="checkbox"/> Institutional <input type="checkbox"/> Administrative			

AUTHORIZATION & ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects me or my dependents' eligibility under this Plan or another employer plan and includes the commencement or termination of adoption proceedings. The rules regarding election changes are described in more detail in the Summary Plan Description.

By participating in NYS Adoption Advantage Account, I understand that by participating I am authorizing The State of New York to take payroll deductions to cover the amount of my annual election.

I understand that I must submit a claim and appropriate documentation (e.g. itemized bill) for out-of-pocket adoption expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Adoption Advantage Account for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Adoption Advantage Account. I certify that I will not submit claims for reimbursement under the Adoption Advantage Account for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Employee Signature _____

Date _____

WageWorks is the administrator of your Plan.
Please return this form via fax 518-473-3581.