

Change Reasons: Rehired Employee • Marriage • Legal Separation • Divorce • Death • Birth • Adoption • Dependent Change • Involuntary Loss of Other Coverage • COBRA • State Continuation (COC) • Return or Go on Leave of Absence • Other Change •

Reason for Application: _____ Date of Event: _____

Employer Name: _____

Member ID: _____ **Phone #:** _____ - _____ - _____
Your Social Security Number or your unique ID Number assigned by your program sponsor.

Name: _____
Last First M.I.

Address: _____
Street Apt.

City State Zip

Email Address: _____

Benefit Election

Pay Periods / year: 10 12 24 26 52 Other: _____ **Effective Date:** _____ / _____ / _____

- Healthcare Election** (Maximum annual election is set by your employer.)
 Per Pay Period Amount _____ X Number of Pay Periods _____ = Your Annual Election (Enter this amount here.) \$ _____ , _____ . _____
- Dependent Care Election (DAYCARE)** IRS maximum set at \$5,000, or \$2,500 if married and filing separate income tax returns.
 Per Pay Period Amount _____ X Number of Pay Periods _____ = Your Annual Election (Enter this amount here.) \$ _____ , _____ . _____

Direct Deposit

Direct Deposit will electronically deposit your reimbursement to your bank account.

Yes, enroll me in Direct Deposit. Checking Savings Name of Bank: _____

_____ _____
 Transit Routing # (First 9 digits on the bottom of your check) Account #

Protected Health Information Authorization

Yes, I authorize BenefitHelp Solutions to share my Protected Health Information (PHI) information with:

Name: _____ Relationship: _____
Last First

For: All benefits / accounts Specific Account(s): _____

For the purpose of: Any and all information Only eligibility and balance info Only claim status info

Participant Authorization
I have read and agree to the terms and conditions on pages 1 and 2 and authorize my employer to reduce my salary on a per pay period basis. I understand that my election cannot be changed or revoked unless I experience a qualified status change event.

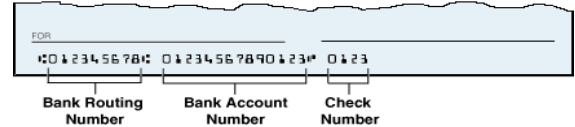
Participant Refusal
I waive participation in the Flexible Spending Accounts. I understand that if I elect not to participate, I cannot enter the program until next open enrollment unless I experience a status change in accordance with Internal Revenue Code Section 125 and submit the changes within 30 days of the qualified status change event.

Employee Signature _____ **Date** _____

Please submit this completed form to your HR department.

DIRECT DEPOSIT

By having your Flexible Spending Account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a Direct Deposit Remittance Advice. The Remittance Advice will indicate the date your claim was paid, the amount that will be deposited to your bank account and an Explanation of Benefits (EOB). All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for any reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.



PHI - Authorization to Release Reimbursement Account Information to Family Members or Designated Individuals

By completing the Protected Health Information Authorization section and signing this application, I hereby authorize the use and disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to BenefitHelp Solutions. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected under federal law. Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose.

IRS AND OTHER REQUIRED TERMS & CONDITIONS

- ACCEPTABLE FSA PLAN TERMS:** I agree to abide by the terms, conditions and provisions of the Plan contained in the Company's Plan Document. I acknowledge my right to examine the Plan Document or obtain a copy from my Human Resources department.
- RESPONSIBILITY:** I acknowledge that the Internal Revenue Code permits me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my FSA elections and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursement from the FSA for disallowed expenses. I will only use my account to pay for eligible Internal Revenue Code (IRC) § 213d health care expenses for myself and/or my tax dependents. Expenses cannot be reimbursed by any other plan. If requested, I will provide appropriate supporting documentation within the specified time frame. I understand that I cannot change or revoke my election until the open enrollment period for the new Plan Year. I will be able to change my election if I have a change in status as outlined in the Plan Document.
- DEPENDENT CARE:** I understand that the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by the FSA.
- PLAN MODIFICATION:** I have been informed that the FSA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the FSA according to their independent judgement and discretion without my consent or prior notice to me.
- SOCIAL SECURITY:** I choose to participate in the FSA knowing that my salary reduction elections may reduce my FICA withholdings (Social Security) and that this may reduce my Social Security benefits upon retirement.
- FORFEITURE:** I understand that I must claim reimbursement for eligible expenses incurred during the plan year for which I was an active participant within the runout period of the plan year (and the Grace Period if applicable) as stated in my Summary Plan Description. If any unused amounts remain in my account(s) these amounts will be forfeited.
- HSA CONTRIBUTIONS:** I understand that if my children, spouse, or I participate in an HSA Plan, HSA contributions may be disallowed if any HSA Participants also participate in the Healthcare FSA Election Account.
- STATUS CHANGE:** Unless otherwise noted in your Plan Documents, Qualified Status Changes (QSC) must be submitted within 30 days of the event. Please discuss with your Human Resources department to determine if your event is a QSC. If there's an election change, I understand that additional funds due to an increase in my election can only be used for claims incurred on or after the date of change.