

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.) \$ _____ , _____ . _____

AutoPay

- Yes, enroll me in AutoPay. Autopay automatically reimburses you for your out-of-pocket expenses processed by ODS. (See page 2 for more details.)

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.

