

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.)    \$ \_\_\_\_\_, \_\_\_\_\_ . \_\_\_\_\_

**Benefits Card**

- Yes, enroll me in a Benefits MasterCard.    A Benefits MasterCard pays directly from your FSA at the point of service.  
 I already have a BHS Benefits MasterCard.    Autopay automatically reimburses you for your out-of-pocket expenses processed by ODS.  
**OR (can only elect one or the other)**  
 Yes, enroll me in AutoPay.    (See page 2 for more details.)

**OR**

**AutoPay**

- Yes, please order a Benefits MasterCard for my dependent. (Only if you elected the card.) Please provide name and ID#.  
**Name:** \_\_\_\_\_  
Dependent Last Name                      Dependent First Name                      Dependent Social Security Number or unique ID Number

**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** \_\_\_\_\_

