Flexible spending accounts Enrollment or change form

BENEFITHelp Solutions

** This information is mandatory. Enrollment may be delayed if fields with an asterisk are not filled out.*

Section 1 Application reason

PLEASE PRINT CLEARLY

* Reason for application	* Change reason	* Effective date

Section 2 Account holder information

* First name	M.I.	* Last name	* Date of birth	* Membership identification or SSN

* Mailing address	* City	* State	* ZIP

* Email address	* Contact number

* Employer	* Group identification number (if known)

Section 3 Benefit election (check all that apply)

☐ Waive participation	You will not be eligible to participate in the healthcare or dependent care account until the next open enrollment period unless an applicable change of status occurs. Please notify your employer of any change in status within 30 days of the applicable change.			
☐ Enroll me in the healthcare flexible spending account (FSA)	Date of first pay period deduction	Number of remaining pay periods	Pay period amount	* Annual election (up to $2,650)
☐ Enroll me in the dependent care assistance program (DCAP) If married and filing seperately, DCAP election should not exceed $2,500	Date of first pay period deduction	Number of remaining pay periods	Pay period amount	* Annual election (up to $5,000)

Pay period amount x Pay periods in the plan year = Annual election

Section 4 Reimbursement (for explanations, please review page 2)

Autopay	☐ Enroll me in autopay	Autopay is not available to you if you are covered by more than one medical insurance plan.	
Direct deposit	☐ Enroll me in direct deposit	☐ Checking ☐ Savings	Bank name
	Rounting number	Account number	

Section 5 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.	
* Employee signature X	* Signature date

Please return to your human resources or benefits department upon completion.

Questions? Contact BenefitHelp Solutions at 888-398-8057.

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 five (5) 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 reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.

Autopay

Autopay is an option for you to be automatically reimbursed for your eligible out-of-pocket medical, dental and prescription expenses processed by Moda Health without having to submit claim forms or supporting documentation. When Moda Health receives a timely claim from your provider, we will process and pay the claim according to your plan benefits. Moda Health will send you an explanation of benefits (EOB), then send the information to BenefitHelp Solutions for automatic reimbursement of eligible out-of-pocket expenses. The amount shown on the EOB under Patient Responsibility is the amount you will automatically receive — up to your annual healthcare FSA election. Orthodontia and IRS-ineligible expenses, such as cosmetic procedures, are excluded from autopay. Unfortunately, you will not be able to use the autopay feature if you have more than one insurance plan with Moda Health.

Terms and Conditions

By signing this application:

1. **Acceptable plan terms.** You agree to abide by the terms, conditions and provisions of the plan contained in your employer's plan documents. These documents are available to you through your human resources or benefits department.
2. **Responsibility.** You acknowledge that the Internal Revenue Code (IRC) permits claim reimbursement only for eligible expenses incurred after the effective date and prior to the termination date of your healthcare flexible spending account, dependent care assistance program and/or commuter expense reimbursement program. You assume full responsibility for all taxes, penalties, interest or other consequences that may be assessed to you by any state, federal or other governmental taxing authority as a result of receiving reimbursement for a disallowed expense. You will only use your account to pay for eligible expenses incurred by yourself and/or your tax dependents. Expenses cannot be reimbursed by any other plan. If requested, you agree to provide appropriate supporting documentation within the requested time frame. You understand that you cannot change or revoke an election until open enrollment or during an applicable change in status.
3. **Dependent care.** You understand that the IRC prohibits you from claiming the Federal Child Care Tax Credit for dependent care assistance program expenses that have been reimbursement through your dependent care assistance program account.
4. **Plan modification.** You have been informed that the plan offered by your employer may be modified from time to time, and you agree that your employer may cancel or amend your plan according to the employer's independent judgment and discretion without your consent or prior notice.
5. **Social security.** You choose to participate in the plan knowing that your salary reduction elections may reduce your FICA withholdings (Society Security) and that this may reduce your Social Security benefits upon retirement.
6. **Forfeiture.** You understand that you must claim reimbursement for eligible expenses incurred during the plan year for which you were an active participant within the run-out period of the plan year (and grace period if applicable), as stated in your Summary Plan Document. If any unused amounts remain in your account(s) after any carryover (if applicable), these amounts will be forfeited.
7. **HSA contributions.** You understand that if you, your spouse or your children participate in an HSA plan, HSA contributions may be disallowed if any HSA participants also participate in the healthcare flexible spending account.
8. **Status change.** Unless otherwise noted in your Plan Documents, Qualified Status Changes (QSCs) 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, you understand that additional funds due to an increase in your election can only be used for claims incurred on or after the date of change.