



Enrollment/Change Form

Flexible Spending Accounts

Employer

Effective Date of Enrollment (MM/DD/YYYY)

Employee Name

Hire Date (MM/DD/YYYY)

Member ID (set by your employer. Typically an employee ID or SSN.)

Birth Date (MM/DD/YYYY)

Street or PO Box

Email Address

City

State

ZIP

Phone Number

Employment Status:

Full Time

Part Time

Please enter your FSA election(s):

Per Pay Deduction Plan Year Election

Medical FSA

Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.

Limited Medical FSA (reimburses dental, vision and/or post-deductible expenses as allowed by your plan)

Note: You cannot elect this account if you elect a Medical FSA. You can elect this account if you are covered under an HSA.

In order to accurately track eligible expenses, apply them to the correct deductible threshold and ensure reimbursement of eligible post-deductible expenses, you must indicate the level of coverage you have under your health insurance.

Single

Family

Dependent Care FSA

This is a:

New enrollment

Change in previous enrollment

If this is a change in enrollment, please check the event that triggered this change:

NOTE:

- An election can only be changed if the change in status affects eligibility for that coverage.
- Any change in election must be consistent with the change in status and the change in eligibility

Participant's termination of employment.

Change in employment status of spouse or dependent (including termination or commencement of employment).

Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).

Change in number of tax dependents (including birth, adoption, placement for adoption, death).

Change in work schedule (reduction or increase in hours by employee, spouse or dependent, including a switch between full-time and part-time, a strike or lockout, and commencement of or return from an unpaid leave of absence).

Change in residence or worksite (of employee, spouse, or dependent).

Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).

Change in dependent care cost or provider (for Dependent Care FSA elections only).

Other:



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Please certify the following:

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature

Date (MM/DD/YYYY)

EMPLOYERS ONLY - This section must be complete for employee to be enrolled

Deduction Cycle: Monthly Semi-monthly Bi-weekly Weekly
 Other:

Pay date of first FSA deduction(s): FSA Pay Dates This Year:

Change in Health Insurance level of Coverage: Single Family

Insurance Coverage Code:

This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.

Submit this document by:

Fax:
(585) 427-9320

Mail:
Benefit Resource, LLC
PO BOX 642
Willow Grove, PA 19090

The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.

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