HealthTrust

SAU #50_____

Flexible Benefits Plan (Limited Purpose) – *Enrollment Form*

Complete this form only if enrolling(ed) in HDHP/HSA

First Name_____ Last Name_____ MI_____ Gender_____ Date of Birth_____ Marital Status _____

Social Security #_____ Home Telephone_____ Work Telephone_____ E-mail Address_____

Mailing Address_____ City_____ State_____ Zip_____

Premium Conversion (Pre-Tax Payroll Deduction of Insurance Premiums)

I understand by electing this option, my share of the premium under the plan(s) chosen below will be deducted from my paycheck on a **pre-tax** basis. I understand that if I do not elect Premium Conversion, my share of the premium under the plan(s) will be deducted from my paycheck on an **after-tax** basis. I also understand that if my premium obligation increases or decreases during the Plan Year, my salary reduction will be adjusted automatically. The amount(s) of my required premium contribution for each plan has been provided to me by my employer in other plan materials. ☐ **I hereby elect to participate in Premium Conversion for the following plans (check all that apply):** ☐ **Medical HDHP** ☐ **Dental**

Health Savings Account (HSA) Contribution

I understand that by electing this option, my contribution to my HSA will be deducted from my paycheck on a pre-tax basis. The amount of my HSA contribution, which I have provided separately to my employer, will be deposited directly to my HSA account together with any contribution by my employer. This election may be changed or revoked at any time during the Plan Year with respect to future paychecks in accordance with my employer's election rules.

❑ **I elect to make my HSA contribution on a pre-tax basis**

Limited Purpose Healthcare Flexible Spending Account (FSA) Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse **IRS-eligible dental care and vision care expenses** that have not been reimbursed under any other plan.

❑ I do ❑ I do not want to participate in the Limited Purpose Healthcare FSA. $_____ X _____ = $_____

Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $ 0 Maximum Contribution Amount $ 2,500

Dependent Care Reimbursement Account Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible dependent care expenses that have not been reimbursed under any other plan. I understand that the IRS requires a Tax ID or the Social Security number of my daycare provider when applying for reimbursement from my Dependent Care Reimbursement Account (DCRA).

❑ **I do** ❑ **I do not** want to participate in the DCRA. $_____ X _____ = $_____

Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $ 0 Maximum Contribution Amount $ 5,000

Salary Reduction Agreement and Signature

I also understand and agree to the following:

- The total amount(s) stated above will be deducted from my paychecks on a pre-tax basis in equal installments throughout the Plan Year. I understand that this will lower my gross pay and, consequently, Social Security earnings for tax purposes.
- Except as otherwise noted in the Health Savings Account Contribution section above, my elections, including any stated salary reduction amount(s), must remain in effect until the end of the Plan Year or my employment termination date, whichever occurs first. However, in the event of a change in my family or employment status (i.e. marriage, divorce, birth, paid or unpaid leave of absence, change in hours, etc.), I may be allowed to change or revoke my election(s) and salary reduction amount(s) in accordance with plan rules.
- I will be obligated to re-pay any mistaken payments I receive from the Plan in accordance with the Plan terms.
- I understand that I may only enroll in the Limited Purpose Healthcare FSA because I am enrolling(ed) in a High Deductible Health Plan/Health Savings Account (HDHP/HSA).
- My Limited Purpose Healthcare FSA will reimburse only **IRS-eligible dental care and vision care expenses** up to my annual election amount (minus any previous payment).
- My Dependent Care Reimbursement Account will reimburse IRS-eligible dependent care expenses only up to my account balance at the time of my request.
- IRS regulations require that I use all of my designated Limited Purpose Healthcare FSA funds and all of my Dependent Care Reimbursement Account funds during the plan year (or during the 2½ month grace period immediately following the plan year if permitted by the Plan) **or forfeit remaining balances**.

Employee Signature _____ **Date** _____

Employer Information

Annual Open Enrollment _____ OR New Hire _____	If New Hire: Date of Hire _____ Effective Date _____	Payroll Calendar: 10-month (26 pays) ___ 12-month (26 pays) ____ 12-month (52 pays)____

HealthTrust

SAU #50_____

Flexible Benefits Plan (Limited Purpose) – *Debit Card Enrollment Form*

Complete this form only if enrolling(ed) in HDHP/HSA

First Name _____ Last Name _____ MI _____

Debit Card

The *Benny™ Prepaid Visa® Card* is a debit card option that is part of the Healthcare Flexible Spending Account (FSA) or Dependent Care Reimbursement Account. Employees participating in the Healthcare FSA or Dependent Care Reimbursement Account may elect to use debit cards to obtain direct reimbursement of Qualifying Expenses, subject to applicable substantiation requirements. If I don't elect a debit card, I will submit a Reimbursement Form to request reimbursement.

Do you want a debit card? (Debit cards expire after 3 years.)

❑ **Yes** If **yes**, 

❑ **No** If **no**, continue to signature

❑ **I did not have a debit card in the prior plan year and want to request one (no charge)**

❑ **I had a debit card in the prior plan year and:**

- ❑ **want to continue using my current card(s) in the new plan year (no charge)**
- ❑ **want to continue using my current card(s) and order an additional set ($5 charge)**

❑ **I had a debit card in the prior plan year but need a replacement set (i.e. lost card). I understand my prior card will be cancelled. ($5 charge)**

Debit Card Required Receipt Information

All charges made to the Card are only *conditionally reimbursed* until related receipts are received and approved by HealthTrust per Internal Revenue Service (IRS) regulations. Documentation of the expense should be submitted to HealthTrust within **14 days** of using the Card to pay for an approved FSA expense. This can be in the form of a bill, receipt of payment (from provider or insurer), explanation of benefits or a written statement from an independent, third party noting the service incurred and its expense amount.

All receipts submitted to HealthTrust should include the following IRS-required information:

- Name and address of service provider
- Date service and expense were incurred
- Name of person receiving the service
- Detailed description of service provided
- Amount charged for service

Credit card slips from *Benny™ Prepaid Benefits Card* transactions cannot be submitted as receipts because they typically do not include all of the information noted above.

Debit Card Agreement and Signature

I also understand and agree to the following:

- If I request a replacement card(s) or additional card(s), I am authorizing a fee of $5 to be debited from my account.
- I certify that the debit card will only be used to pay for my IRS-eligible dental care or vision care expenses or those of my spouse or dependent(s) that have not been reimbursed, and I will not seek reimbursement for such expenses under any other plan.
- I understand that I am required to submit and retain paper substantiation for all expenses charged to the debit card unless otherwise permitted by the FSA Administrator in accordance with applicable IRS rules.
- I understand that the debit card can only be used during the current Plan Year and cannot be used in any applicable grace periods.
- I understand and agree that misuse of the debit card will result in suspension or permanent revocation of the card and I will be obligated to repay any ineligible expenses that have been reimbursed.

Employee Signature _____ **Date** _____

Be sure to attach this form to the Flexible Benefits Plan (Limited Purpose) Enrollment Form