HealthTrust
Benefit Advantage

Greenland School District
Flexible Benefits Plan – *Enrollment Form*

Do not complete this form if you (or your spouse) are covered by a HDHP/HSA. Please see HR for details.

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 that 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. 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. 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 plan(s) (check all that apply): ❑ Medical ❑ Dental**

Health Flexible Spending Account (Health 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 healthcare expenses that have not been reimbursed under any other plan.

❑ **I do** ❑ **I do not** **want to participate in the Health FSA.**

$_____ X _____ = $_____
Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $ 0 Maximum Contribution Amount $ 2,550

Dependent Care Assistance Plan Account (Dependent Care 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 the Tax ID or the Social Security number of my daycare provider when applying for reimbursement from my Dependent Care Account.

❑ **I do** ❑ **I do not** **want to participate in the Dependent Care Account**

$_____ X _____ = $_____
Employee Per Pay Period Election # of Pay Periods Annual Employee Election

Minimum Employee Contribution $ 0 Maximum Employee Contribution $ 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.
- My elections, including any above 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.
- My Health FSA will reimburse IRS-eligible healthcare expenses up to my annual election amount minus any amounts previously reimbursed. I (or my spouse if applicable) cannot make contributions to a Health Savings Account (HSA) while I am participating in the Health FSA.
- My Dependent Care 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 Health FSA funds and all of my Dependent Care 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 _____ (check one)	If New Hire Date of Hire _____ Effective Date _____	Date of First Payroll: _____ Payroll Calendar: 10-month (21 pays) _____12-month (26 pays)_____

HealthTrust
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Greenland School District

Flexible Benefits Plan – *Debit Card Enrollment Form*

First Name _____ Last Name _____ MI _____

Debit Card

The Benefit Advantage Debit Card is a debit card option that is part of the Health FSA or Dependent Care Account. Employees participating in the Health FSA or Dependent Care 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 to use a debit card? (Debit cards expire after 3 years.)	
❑ **Yes** If **yes**, 	❑ **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)**
❑ **No** If **no**, continue to signature	❑ **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.

*Documentation is not required if the expense equals the co-payment amount required by 1) your employer's medical plan for a doctor's office visit, or 2) your employer's pharmacy plan for a prescription. Also, the IRS requires that the Card work only at discount stores, department stores and supermarkets that can identify FSA-eligible items at checkout; therefore, documentation of those purchases is not required.

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 the Benefit Advantage Debit Card transactions cannot be submitted as receipts because they typically do not include all of the information noted above. Also, if your employer allows over-the-counter items to be covered under your FSA plan, receipts must have each item's name printed on them; handwritten item names are not acceptable.

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 healthcare and/or dependent 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 Enrollment Form