

Flexible Benefits Plan ENROLLMENT FORM

PLEASE PRINT CLEARLY:

Once completed, please return this form to your Employer

Employee Information

Employee Name _____
Last Name First Name MI

SSN _____ Date of Hire ____/____/____ Date of Birth ____/____/____

EEID _____ Email Address _____

Home Address _____

City State Zip

Home Telephone No. (_____) _____ Work Telephone No. (_____) _____ Ext. _____
area code area code

Employer Name _____ Div./Loc./Dept./ # _____

Payroll Mode: Weekly Bi-weekly Semi-monthly Monthly Other _____

Dependent Care Reimbursement Account

I elect to participate in the Dependent Care Reimbursement Account program sponsored by my employer. Further, I elect to contribute \$ _____ Annually.

I elect not to participate in the Dependent Care Reimbursement Account program at this time.

Employee Certification

I understand that my annual FSA election may require adjustment to comply with IRS Section 125, 129 and 105 nondiscrimination guidelines. I also understand that I may not change or stop deposits to the account(s) indicated above until the end of the plan year unless I have a change in status, as defined by IRS regulations and my employer's plan. **If I do not use all the money in my account(s) by the end of the Plan Year, I understand that any balance will be forfeited.** I understand that there will be no interest build-up in the account(s). I have read and understand the rules and regulations on the reverse side of this form.

I certify that the Flex Debit Card, if applicable will only be used for expenses considered eligible as defined under the Flexible Spending Account Summary Plan Description. I certify that these expenses have not been and will not be reimbursed through any other means, including my or my dependent's insurance plans. I will repay funds in the event that I misuse the Flex Debit Card to authorize payment of any non-eligible expenses, or fail to provide sufficient documentation within the stated time frame, as explained in the Procedure for Obtaining Reimbursement, Submission of Documentation section.

My signature authorizes reductions from my pay checks for the purpose of funding my tax-free reimbursement account(s).

Employee Signature _____ Date _____

FOR FLEX DEBIT CARD HR USE ONLY

For Medical FSA enrollees, please list the plan in which they are participating in: _____ and the participant's health plan Member Identification Number _____ (if different than SSN). This information is required for setting up auto substantiation of co-payment transactions.

If the participant has chosen to waive their employer provided health plan, please check this box: Opt Out/Waived

Authorized by _____ Date _____



IMPORTANT INFORMATION REGARDING REIMBURSEMENTS DEPENDENT**

ELIGIBLE EXPENSES:

The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or \$5,000, whichever is less. If you are married, filing separately, your annual reimbursement cannot exceed \$2,500.

The expenses must be employment-related and incurred for the care of a dependent of the employee who is under age 13 and for whom the taxpayer is entitled to a dependent deduction under Internal Revenue Code Section 151(c), or is a dependent of the employee who is physically or mentally incapable of caring for himself or herself, resides with the employee for more than ½ of the year, earns below \$3,200 and will not be deducted or taken as tax credits on the employee's federal and/or state income tax return for any year.

The payments cannot be made to a person who is claimed as a dependent by the employee.

Expenses for DAY camp programs are allowable; however, if camp hours exceed the employee's working hours, submit ONLY that portion of expenses incurred for work-related hours. **OVERNIGHT CAMP is NOT an allowable expense, even on a prorated basis.**

SUPPORTING DOCUMENTATION:

For all expenses, you must attach bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Name and address of service provider
3. Nature of service
4. Amount reimbursable under the plan
5. Date service was rendered
6. Provider's Tax ID Number

**QUALIFICATION GUIDELINES FOR A DEPENDENT CARE ACCOUNT

To qualify, both the employee and spouse must be working, or one working and the other enrolled as a full-time student, or actively looking for work. If the employee is single, divorced or legally separated, the employee's need for dependent care assistance must be work related.

PLEASE NOTE

Service dates for reimbursable expenses must fall within the plan year. Reimbursement requests not submitted during the plan year must be submitted prior to the end of the run out period. Please contact your Human Resources Department or Crosby Benefit Systems for more information.



Crosby Benefit Systems, Inc. - 800-462-2235 - Fax 617-928-0001 - servicecenter@crosbybenefits.com
PO Box 929125, Needham, MA 02492-9125 - www.crosbybenefits.com - version 0108