

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

EMPLOYEE INFORMATION Open Enrollment New Hire Hire Date _____ Effective Date _____

Company Name _____

Participant Name (First, MI, Last) _____

Street Address New Address _____

Social Security Number _____

City, State, Zip _____

Day Telephone _____

E-mail Address (all notifications will be sent via e-mail) _____

Date of Birth _____

FLEXIBLE SPENDING ACCOUNT (FSA)

I elect to Participate: Yes: No: \$ _____ per pay period x _____ pay periods = \$ _____ annually
(not to exceed Employer Limit _____) (do not round annual amount)

DEPENDENT CARE ASSISTANCE PLAN (DCAP)

I elect to Participate: Yes: No: \$ _____ per pay period x _____ pay periods = \$ _____ annually
(not to exceed \$5,000 per single or married person filing jointly, or \$2,500 per married person filing separately) (do not round annual amount)

HEALTH SAVINGS ACCOUNT (HSA)

Do you or your spouse have a Health Savings Account? Yes: No:

(If yes, you may participate in a Limited Purpose Flexible Spending Account that covers dental, vision, and preventive care only)

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPF) DENTAL, VISION AND PREVENTIVE CARE ONLY

I elect to Participate: Yes: No: \$ _____ per pay period x _____ pay periods = \$ _____ annually
(not to exceed Employer Limit _____) (do not round annual amount)

PRE-TAX PREMIUM DEDUCTION OPTIONS* Please check one of the following two options:

- I do not want any of my premiums deducted on a pre-tax basis.
- I do participate in my employer's group plan of benefits and would like my premiums deducted pre-tax from my paycheck.

PLAN OPTIONS

I agree to use Direct Deposit for my manual reimbursements. (please complete Direct Deposit form)

Automatic Reimbursement Option - Authorization

I authorize EBS to automatically reimburse eligible amounts under IRC Section 213(d) from my Flex Spending Account after my insurance claims have processed. I understand that if there is an overpayment due to reprocessing or held claims, that I will be responsible to repay my Flex Spending Account. Any other expenses must be requested by using a manual reimbursement claim form.

PLAN AGREEMENTS

I request that my periodic paychecks for the plan year be reduced on a pro rate to the plan with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the plan document. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. If I terminate, go on leave, or retire I can only be reimbursed for eligible health care expenses I have incurred on or before my date of termination, leave, or retirement. I have examined this agreement and to the best of my knowledge it is true correct and complete.

Employee Signature: _____

Date: _____