benefit strategies LLC

MADISON COUNTY COMMISSION
FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

A. Employee Information ☐ Enroll ☐ Decline (Skip to Section E) *Please Print Clearly!*

Name: _____ Social Security Number (Required): _____

Home Address:

Check if New: ☐ _____

City: _____ State: _____ Zip Code: _____ Day Phone: _____

E-mail Address (Required): _____ Date of Birth: _____

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Reimbursement Account Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body".

$	X		=	$
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Maximum Annual Election Allowed
$2,750

2. Dependent Care Assistance Account Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

$	X		=	$
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Maximum Annual Election Allowed
$5000
($2,500 if married filing separately)

C. *FlexExpress*© Debit Card A set of 2 FlexExpress Cards© will be mailed out to you automatically. If you would like additional cards for your dependents, please indicate your selection below.

☑	FlexExpress Cards© Debit Card	You will automatically receive a set of 2 FlexExpress Cards©

Additional Card Information: Please indicate the number of *additional* cards you would like to request below (If you request a card for yourself you will get 2 to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.) Additional sets are $5.00 per set, debited from your FSA.

Number of Additional Sets Requested:

D. Direct Deposit Authorization If you would like non debit card reimbursements to be direct deposited to your bank account (rather than receiving paper checks) fill out the information below EACH PLAN YEAR AND attach a voided check. If you do not complete this information each plan year you will be defaulted to check.

Bank Name:
(See #1 on sample)

☐ Checking Account
☐ Savings Account

Routing Number - 9 digits (See #2 on sample):

Account Number (See #3 on sample): _____

SAMPLE

E. Signatures By signing below, I agree to the following terms and conditions:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts *cannot* be reimbursed from any other source and *must* be incurred during the Plan Year.
- I understand that my employer may allow me to carryover unused funds up to plan limits at the end of the plan year for deposit into the next following plan year for future use. Any money unclaimed from my Health Care Reimbursement Account(s) at the end of the Plan Year in excess of the carryover limits will be forfeited to my employer after a run-out period. I will not receive it back.
- For expenses reimbursed through this account I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
- The IRS requires me to keep documentation of all my expenses claimed and supply them to Benefit Strategies if requested.
- I have read and understood all of the plan details outlined in my Summary Plan Description.

Employee Signature (required):		Date:	
Employer Acceptance (required):		Benefit Effective Date:	
*If this is a mid-year enrollment, please list the first payroll date for deductions.		First Payroll Date:	