Employee Benefit Management Services, Inc.

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FSA ENROLLMENT FORM

SECTION A: Demographic Information

Employer				E-mail Address
Employees Last Name	First Name	M.I.	Gender	Marital Status ☐ Single ☐ Married
Social Security Number	Date of Birth	Phone Number		
Current Mailing Address Street City State Zip				

SECTION B: Elections

Note: If you or your spouse participate or plan to participate in a Health Savings Account, you are ineligible to participate in a Health FSA.

Plan Year from _____through _____ (MM/DD/YY)

I elect to receive the following coverages under the Cafeteria Plan:

Flex Coverage (X if Yes)	Per Pay Period Deduction	X	Number of Deductions	=	Annual Election
☐ Health Flexible Spending Account	_____		_____		_____
☐ Dependent Care Assistance Plan	_____		_____		_____
☐ _____	_____		_____		_____

Pre-tax Insurance Premium Payment (X if yes)	Premium Deduction	
☐ Health Insurance Premium	_____	This is a type of a flexible benefit plan that permits eligible employees who are covered under an employer–sponsored life insurance and /or health plan coverage to elect to reduce their compensation to pay for their share insurance premiums on a pre-tax basis. This includes employer -sponsored health, group term life, disability, dental, vision, or AD&D insurance plans.
☐ Vision Insurance Premium	_____	
☐ Dental Insurance Premium	_____	
☐ _____	_____	

Auto Flex

☐ I elect Auto Flex ☐ I decline Auto Flex

Auto Flex will allow eligible Medical, Dental, Vision, and/or RX claims for you and your dependents to automatically be reimbursed from your Health FSA once they have been processed by the EBMS Health plan. If you elect this option, it will be in effect for **all** claims until your Flex Account balance has been exhausted.

- Auto Flex cannot be elected if you have heath insurance covering yourself or any of your dependants who are also covered under another health plan. Do you or your dependents have other insurance coverage through EBMS or another entity? ☐ Yes ☐ No
- Participants must elect or deny Auto Flex each Plan Year; the feature will not roll over from one Plan Year to the next.
- By electing Auto-Flex, I agree that I (or a tax dependent) have incurred the expenses and they were not reimbursed and are not reimbursable by any other benefit plan and I will not claim the expenses reimbursed through my Health FSA as deductions or credits when filing my individual tax returns. I agree to refund the plan for any Health FSA reimbursement I receive that fails to meet any of the previously stated conditions.

SECTION C: Signature

Note: There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask the Plan Administrator if you have any questions. With regard to my salary reduction agreement and my election of benefits, I understand that:

- I may not change the election during the Plan Year unless there is a change in my family status (e.g. termination of employment or change to part time status by either myself or my spouse, marriage, divorce, death of my spouse or child, adoption or birth of my child) if the change is allowed by my Flex Plan Document.
- My employer and I agree that my compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).
- The Plan Administrator is authorized to adjust the amount of my salary reduction and benefits if it is necessary to satisfy certain provision of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My election of salary reduction and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.
- My Social Security benefits may be reduced as a result of my election.
- Signing this Agreement does not initiate my coverage under the insurance policies. I must complete a separate health insurance enrollment form to start my health insurance coverage.
- I understand and agree that this agreement is: 1. Subject to the terms of the company's Cafeteria Plan, Medical Reimbursement Plan, and/or Dependent Care Assistance Plan as amended from time to time; 2. Shall be governed by and construed in accordance with applicable laws; 3. Shall take effect under applicable laws; and 4. Revokes any prior election and compensation reduction agreement relating to such plan(s).

Employee Signature _____ Date_____

Please return this completed form to your employer.