HEALTH ECONOMICS GROUP, INC.

BEMUS POINT CENTRAL SCHOOL DISTRICT

FLEXIBLE SPENDING ACCOUNT

2019-2020 ENROLLMENT FORM

EMPLOYEE INFORMATION (Please PRINT clearly)

Employee Name:	Employee Social Security Number:

Mailing Address:	City:	State:	Zip Code:

Email:	Home Telephone:	Work Telephone:

Birth Date (Month / Day / Year)	Gender:	Marital Status:	Effective Date: Month/Day/Year	Employer Signature:
	☐ Male ☐ Female	☐ Single ☐ Married	PAYROLL USE ONLY ___ / ___ / ___	

DEPENDENTS (Please PRINT clearly)

Name	Relationship	Birth Date	Social Security #
	spouse		
	☐ Daughter ☐ Son		
	☐ Daughter ☐ Son		
	☐ Daughter ☐ Son		

EMPLOYEE ELECTIONS

Benefit Election Options	Participation	Employee Dollars	Employer Dollars	9/01/19 – 8/31/20 Plan Year
Medical Expenses Maximum of **$2,700.00** per plan year.	YES ☐ NO ☐	$_____	$_____	$_____
Dependent Care Expenses Maximum of **$5,000** per plan year. ($2,500 if married filing separately)	YES ☐ NO ☐	$_____	$_____	$_____

NOTE: Amounts allocated to Health Care and/or Dependent Care are deducted on a pre-tax basis.. New employees; if you enroll after the beginning of the Plan Year, pay period amounts will be prorated according to the length of time remaining in the plan year. If an annual amount is not evenly divisible by the number of pay periods, the pay period amount will be rounded downward. **YOU MUST COMPLETE AND SUBMIT FEDERAL FORM W-10 FOR EACH CHILD CARE PROVIDER.**

IMPORTANT: By enrolling in the Flexible Spending Arrangement I understand that:

- **I will be paid from the reallocation account(s) upon submission of properly prepared claim forms.**
- **Dependent Care expenses will be reimbursed up to the balance funded through payroll deductions.**
- **I may not change my election during the Plan Year except for a change in family status.**
- **I may not transfer money between options (Medical and Dependent Care).**
- **I will forfeit any balance remaining 90 days after year end.**

A WEX HEALTH PAYMENT CARD will be provided for use with my FSA Medical Expense Account, and I agree that I and my dependents (if any) will use the debit card solely for its intended use. I understand that I must submit documentation substantiating any and all of my purchases upon request from Health Economics Group. If this card is misused in any way, I understand that it will be closed for future use, and it will remain my responsibility to reimburse the plan for all ineligible expenses. Further, I agree to read and to abide by all terms described in detail with materials received with my Wex Health Payment Card. Should I request a replacement debit card, I am aware that there is a $10 fee that will automatically be deducted from my plan balance.

I ELECT TO HAVE MY 2019-2020 INSURANCE PREMIUM CONTRIBUTION TAKEN FROM MY PAY ON A PRE-TAX BASIS. ☐ Yes ☐ No

I ELECT TO OPT OUT OF THIS BENEFIT for 2019-2020 ☐ Yes ☐ No

DIRECT DEPOSIT BANK INFORMATION - Must attach a voided check (not a deposit slip) or a bank letter for account verification.

I wish to receive my plan payments by Direct Deposit. I hereby authorize Health Economics Group, Inc. (HEG) to originate electronic credit transactions to my bank (or credit union or savings & loan) account indicated below and to credit the same to such account. If necessary, HEG may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until HEG has received written notification from me of its termination in such time as to afford HEG and my bank a reasonable opportunity to act.

Bank Name:	Routing Number:

Account Type: Checking ☐ Savings ☐	Account Number:

Employee Signature: _____ **Date:** _____

As a participant, I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have a change in status. Changes in status include: marriage, divorce, legal separation or annulment; death of a spouse or child; birth or adoption of a child; termination or commencement of employment of a spouse; you or your spouse's employment status changes from full-time to part-time or vice versa; you or your spouse take an unpaid leave of absence. In addition to those above, there are certain added limited situations when you can change your elections for your *insured benefits only*. You are permitted to change elections if you have a change in status which results in you, your spouse or dependent's gaining or losing eligibility for coverage under your employer's health plan or your spouse's or dependent health plan. The change you make must be consistent with that gain or loss of coverage: a reduction or increase in hours of employment by the employee, spouse, or dependent including a switch between part-time and full-time, a strike or lock-out, or commencement or return from an unpaid leave of absence; an event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or student status; a change in the place of residence or worksite of the employee, spouse or dependent, or any similar circumstance as provided in the accident or health plan under which the employee receives coverage. Any change in benefit elections resulting from a change in status must correspond, be consistent and on account of the status event. If you experience a change in status and wish to change your benefit elections, it is your responsibility to notify the Benefits Specialist within 30(thirty) days of the date of the event.

- The Benefits Specialist may reduce or cancel my compensation reduction or otherwise modify this agreement in the event the Benefits Specialist believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

- Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my insured benefit elections then in effect for the new Plan Year but not my non-insured benefits. In addition, this compensation **reduction agreement** will continue by its terms in the amount of the required contribution for the insured benefit options.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S SECTION 125 PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UDNER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

MEDICAL INSURANCE WAIVER

I elect to waive coverage under Bemus Point Central School District Group Insurance Plan(s). I understand that I may not change this election during the Plan Year except in the case of a qualified Change in Status.

Signature_____ Date_____

I am covered by other Health Insurance through _____ Carrier_____
Spouse/Parent/Government

HR USE ONLY

Date of FT Employment _____ Benefit Enrollment Date _____ Department _____