BRi Benefit Resource, Inc.

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# ENROLLMENT FORM
# FLEXIBLE SPENDING ACCOUNTS
*(PLEASE PRINT CLEARLY)*

**EMPLOYER:**

**EFFECTIVE DATE OF ENROLLMENT:** / /

## A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time

Email Address: _____

*(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)*

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with Section 125 of the Internal Revenue Code.

## B. FLEXIBLE SPENDING ACCOUNTS (FSAs) *Please enter your FSA election(s) below.*

***You can only elect the accounts offered by your plan. Refer to your Plan Highlights for the type of accounts and election maximums you can elect.***

| | Per Pay Deduction | Plan Year Election |
|---|---|---|
| ☐ Medical FSA<br>*Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.* | $ _____ | $ _____ |
| ☐ Limited Medical FSA *(reimburses dental, vision and/or post-deductible expenses as allowed by your plan)*<br>*Note: You cannot elect this account if you elect a Medical FSA. You can elect this account if you are covered under an HSA.*<br>*In order to accurately track eligible expenses, apply them to the correct deductible threshold and ensure reimbursement of eligible post-deductible expenses, you must indicate the level of coverage you have under your health insurance.* ☐ Single ☐ Family | $ _____ | $ _____ |
| ☐ Dependent Care FSA | $ _____ | $ _____ |

## C. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

☐ I choose to participate in the plan.

☐ I decline to participate in the plan. *(This information is to be retained for the Employer's records only and not reported to Benefit Resource.)*

Signature: _____ Date: ____/____/____

## D. PAYROLL DEDUCTION INFORMATION *Employer must complete this section for employee to be enrolled.*

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other _____
- **Pay Date of first FSA deduction(s):** ____/____/____
- **Number of pay dates on which FSA deduction(s) will be taken during this plan year:** ____
- **Health Insurance Level of Coverage:** ☐ Single ☐ Family
- **Health Insurance Coverage Code:** ___ ___ ___ ___ ___ ___ ***This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.***

*The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.*
*The Beniversal Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. Card accepted at qualified merchants accepting Debit Mastercard. The Bancorp Bank; Member FDIC.*