# FLEXIBLE SPENDING ACCOUNT
## ENROLLMENT/CHANGE FORM

| Benefits Administered By<br>MVP Select Care, Inc<br>120 Madison St, Suite 1000, Tower 2, Syracuse, NY 13202<br>315.422.1533 ♦ 888.222.9931 | Company Name: _____<br><br>Plan Year Start Date:_____ |
|---|---|

**TYPE OF ENROLLMENT**

- ☐ Regular Annual Election
- ☐ Mid-Year Election **Effective Date:**___/___/___
- ☐ Change in Family Status

If Mid-Year Election, date of first payroll deduction: ___/___/___
If change in family status, date of event: ___/___/___
Date of first payroll deduction after change becomes effective___/___/___
If change in family status, change is due to: ☐ Divorce/separation
☐ Marriage ☐ Birth or Adoption of child ☐ Death of spouse/child
☐ Spouse becomes employed ☐ Spouse ceases to be employed
☐ Change in work hours ☐ Unpaid leave of absence
☐ Other (explain)_____

**EMPLOYEE INFORMATION (please print)**

| Employee Name (last, first, middle initial) | Payroll Cycle: ☐☐ ☐ Weekly ☐ Monthly ☐ Bi-weekly ☐ Bi-monthly |
|---|---|
| E-Mail Address: | Mobile Number: |
| Street Address: | Phone Number: |
| City, State, Zip: | Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced |

| Social Security Number: | Date of Birth: | I would like to receive reimbursement through direct deposit:<br>☐ **Yes** ☐ **No**<br>***If Yes, please complete Electronic Funds Transfer Agreement form.*** |
|---|---|---|
| - - | / / | |

**ENROLLMENT AND ELECTION INFORMATION**

I authorize my employer to deduct pre-tax contributions from my compensation for the following benefits:
☐ **Medical Reimbursement Account** (reimbursement for family health care expenses not paid from any other source).
☐ **Dependent Care Reimbursement Account** (day care expenses for eligible dependents)

| | **Pre-Tax Deductions** | | |
|---|---|---|---|
| | | **To be completed by Human Resource Department** | |
| Plan Type | **Annual Election** | **Date of First Payroll** | **Per Pay Period Deduction** |
| **Medical Reimbursement**<br>Limit set by employer up to IRS Maximum | $ _____ | _____ | $ _____ |
| **Dependent Care Reimbursement**<br>Limit Set by employer up to IRS Maximum | $ _____ | _____ | $ _____ |

***If married & filing federal income taxes jointly, the maximum annual contribution amount allowed is $5,000.00. If married & filing separate returns, the maximum annual contribution amount allowed is $2,500.00. Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.***

Upon enrollment you will receive the CareFund Debit Card. I understand and agree that this card is only to be used to pay for qualified medical expenses that will not be reimbursed from another source. I understand that I am still responsible to acquire and retain documentation to substantiate any expenses.
☐ **Yes** ☐ **No**

***Additional Debit Cards Requests:***

Would you like to request a debit card for your spouse or dependent? ☐ **Yes** ☐ **No**

**Spouse Name:**_____ **Soc. Sec. Number:** _____ **DOB:** _____

**Dependent Name:**_____ **Soc. Sec. Number:** _____ **DOB:**_____

**Dependent Name:**_____ **Soc. Sec. Number:**_____ **DOB:**_____

All Dependents must be age 18 or over in order to receive the MVP CareFund Card. Cards will be mailed to your home address in a plain white envelope. If you previously added a dependent they will automatically be linked to the plan each year. It is your responsibility to notify the plan once a dependent is no longer eligible or you wish to term them from the plan.

***AUTHORIZATION OF PARTICIPATION***

I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

**Employee Signature** _____ **Date** _____

**HR Representative** _____ **Date** _____