Flexible Spending Account

MVP HEALTH CARE

Enrollment or Change Request

Need help completing this form? Call **1-888-222-9931** for assistance.

Employer Name _____ Plan Year Start Date _____

CHECK ONE X

☐ **Regular Annual Election**

☐ **Mid-Year Election** Effective date: _____ Date of first payroll deduction: _____

☐ **Change in Family Status** Date of event _____ Date of first payroll deduction after change: _____

- ☐ Divorce/separation
- ☐ Death of spouse or child
- ☐ Change in work hours
- ☐ Marriage
- ☐ Spouse became unemployed
- ☐ Unpaid leave of absence
- ☐ Birth or adoption of a child
- ☐ Spouse ceases to be employed
- ☐ Other (explain): _____

EMPLOYEE INFORMATION (PLEASE PRINT)

Employee Name *(Last, First, MI)* _____ Date of Birth ___/___/___

Street Address _____ Social Security No. _____

City _____ State _____ Zip Code _____ Employee ID _____

Email _____ Telephone _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced | Payroll Cycle ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Bi-monthly

FAMILY MEMBERS ASSOCIATED WITH THIS FLEXIBLE SPENDING ACCOUNT (FSA)

	Name	Social Security No.	Date of Birth
☐ Spouse			
☐ Dependent			
☐ Dependent			
☐ Dependent			

ENROLLMENT AND REIMBURSEMENT ACCOUNT ELECTION

I authorize my employer to deduct pre-tax contributions from my compensation for the following benefits:	**ANNUAL PRE-TAX DEDUCTION ELECTION**	*TO BE COMPLETED BY EMPLOYER HUMAN RESOURCES DEPT.*	
		DATE OF FIRST PAYROLL DEDUCTION	**PER PAY PERIOD PRE-TAX DEDUCTION**
☐ Medical Reimbursement Account *(Reimbursement for family health care expenses not paid from any other source)*	$		$
☐ Dependent Care Reimbursement Account* *(Reimbursement for day care expenses for eligible dependents)*	$		$

**If you are married and file federal income taxes jointly, the maximum annual dependent care contribution amount is $5,000. If you are single, or are married and file separate tax returns, the maximum annual dependent care contribution amount allowed is $2,500. Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.*

☐ ***Yes*, I would like to receive reimbursements through direct deposit to a checking or savings account.** (If selecting this option, please complete the *Direct Deposit Authorization for MVP Flexible Savings Accounts and/or Health Reimbursement Arrangements* form and return it to MVP with this form. You can obtain the form from your Employer or by emailing **myspendingaccounts@mvphealthcare.com**.)

Employee Authorization of Participation By signing below, I authorize my employer to reduce my pay on a per pay period basis as indicated on page 1. 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 Name (print) _____ *Signature* _____ *Date* _____

Employer Human Resources Representative Name (print) _____ *Signature* _____ *Date* _____

Return this completed form by mail to: ATTN: MVP ANCILLARY SERVICES
MVP HEALTH CARE
PO BOX 2207
SCHENECTADY NY 12303

Or by email to: **myspendingaccounts@mvphealthcare.com**