



GROUP INSURANCE COMMISSION FLEXIBLE SPENDING ACCOUNT ENROLLMENT & CHANGE FORM



PLAN YEAR: JANUARY 1, 2011 TO DECEMBER 31, 2011

A. Employee Information Please Print Clearly! Instructions on Back

Name: _____ Social Security Number: _____
 Home Address: _____
 Check if New: _____
 City: _____ State: _____ Zip Code: _____ Day Phone: _____
 E-mail Address: _____ Date of Birth: _____
 Agency Name: University of Massachusetts President's Office Employee ID#: _____

B. Election Information Please Print Clearly! Instructions on Back

1. Health Care Spending Account (Enter your election below:) Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body".

\$ _____	X	_____	=	\$ _____	
Your Contribution Per Pay Period		# of Pay Periods		Total Election	Maximum Election allowed \$500 minimum/\$5,000 maximum

2. Dependent Care Assistance Program (Enter your election below:) Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

\$ _____	X	_____	=	\$ _____	
Your Contribution Per Pay Period		# of Pay Periods		Total Election	Maximum Election allowed \$5,000 (\$2,500 if married filing separately)

C. FlexExpress® Debit Card HCSA participants will automatically receive a debit card. A \$5.00 fee will be assessed annually for each dependent card you elect. If you would like to order a card for your spouse or a dependent, please indicate your selections below.

Information: List your spouse or dependents (over age 18) for whom you would like to order a FlexExpress® Card. This applies to your legal dependents only. *Domestic/Civil Union Partners are not IRS eligible dependents, in most cases.*

Full Name	Social Security Number	New Card
1. _____	_____	___New
2. _____	_____	___New

D. Direct Deposit Authorization If you would like non-FlexExpress® reimbursements to be direct deposited to your bank account (rather than receiving paper checks), fill out the information below EACH PLAN YEAR AND attach a voided check.

Bank Name: _____ (See #1 on sample)	<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	<div style="text-align: center; font-weight: bold; font-size: small;">SAMPLE</div>										
Routing Number - 9 digits (See #2 on sample): <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>											Account Number (See #3 on sample): _____	

E. Signatures By signing below, I agree to all of the Terms and Conditions stated on the opposite side of this form.

Employee Signature (required): _____	Date: _____
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TO BE COMPLETED BY PAYROLL COORDINATOR

Benefit Effective Date:	Qualifying Event Date:	Date of Hire:	
Agency Name/Division #: <u>UMass President's Office UMS/0149</u>	Division HR Coordinator:	<u>Anna Pitocchelli</u>	
Phone #: <u>774-455-7568</u>	Email Address:	<u>apitocchelli@umassp.edu</u>	
Reason for Enrollment:	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Change of Status		

Enrollment Form Instructions

Section A	EMPLOYEE INFORMATION - Please print your name and complete address clearly. Your phone number and e-mail address will be used only to communicate with you with regard to this plan. It will not be distributed to any other organization or used for marketing purposes in any way. Statements of your account balance and activity will be sent via e-mail whenever possible. Please understand that this is an employee account and due to federal and state laws we cannot release detailed information to anyone other than the participant, this also includes your spouse and/or dependent(s). Please contact our office for further information.
Section B	FLEXIBLE BENEFIT PLAN PRE-TAX ELECTIONS <ol style="list-style-type: none"> 1. Health Care Spending Account - Carefully consider how much money you would like to set aside each pay period during the Plan Year to pay for your family's eligible out-of-pocket medical expenses. Make sure you read your Summary Plan Description and/or the Health Care brochure to fully understand how the plan works. 2. Dependent Care Assistance Program - Carefully consider how much money you would like to set aside each pay period during the Plan Year to cover the expenses you will incur to care for your eligible dependents while you and your spouse (if applicable) are gainfully employed. Make sure you read your Summary Plan Description and/or the Dependent Care brochure to fully understand how the plan works.
Section C	FlexExpress® Debit Card - You may order an additional card for your spouse or children over 18 if desired. A fee of \$5.00 will be assessed to your account for each spouse/dependent card.
Section D	Direct Deposit Authorization - Claims that are faxed, mailed or filed on-line are normally reimbursed by sending you a paper check. If you would like your reimbursements sent directly to your checking or savings account via Direct Deposit, fill out this section and attach a voided check (for checking) or deposit slip (for savings). Confirmations are sent via email and will show current transaction information, as well as, available funds in the account.
Section E	Signatures - After you have completely filled out this form and carefully read the following Terms and Conditions please sign and date then return the enrollment form to the HR office as applicable. Employers must review the elections and sign that the employee meets the eligibility requirements.

Flexible Benefit Plan Terms and Conditions

I UNDERSTAND THAT:

- **ADMINISTRATIVE FEES:** I understand by participating in the Flexible Reimbursement Plan(s) my employer will deduct pre-tax from my pay check: \$3.60 per month.
- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts *cannot* be reimbursed from any other source and *must* be incurred during the Plan Year. Any money unclaimed from my reimbursement account(s) at the end of the Plan Year will be forfeited to my employer after the run-out period. I will not receive it back.
- I may have an additional 2½-month Grace Period at the end of the current plan year to incur eligible expenses for reimbursement. See your Flexible Benefit Plan Summary Plan Description for more details.
- I understand that Flexible Benefit Plans are to reimburse expenses incurred by my legal dependents or myself only. *Domestic/Civil Union Partners are not IRS eligible dependents in most cases.*
- Health Care Spending Accounts will be reimbursed up to the annual election (minus previous payments). The Dependent Care Assistance Program will be reimbursed up to the balance currently credited to the account.
- 1. **FlexExpress® Card:** The FlexExpress® Card is to be used only to pay for IRS eligible health expenses. It cannot be used to purchase any items or services not specifically approved by IRS guidelines.
 2. For expenses paid with the FlexExpress® Card I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
 3. The IRS requires me to keep documentation of all my expenses the card is used for, and supply them to Benefit Strategies if requested.
 4. Misuse of the FlexExpress® Card will result in permanent revocation and repayment of ineligible expenses.

IMPORTANT INFORMATION REGARDING ENROLLMENT AND CHANGES

ADMINISTRATIVE FEE
The cost to administer this program is paid for by each employee on a before tax basis. The monthly administrative fee is \$3.60 - for Health Care Spending Account (HCSA) alone, Dependent Care (DCAP) alone or for HCSA/DCAP combined.
ANNUAL MAXIMUM AND MINIMUM FOR HCSA AND DCAP
HCSA: Active state employees who are eligible for GIC benefits. The waiting period is the same as for other GIC life and health benefits. DCAP: Active state employees and contract employees who work at least 18.75 hours per 37.5 hour work week or 20 hours per 40 hour work week. You are eligible on the first day of employment. Enrollment forms must be submitted to your Payroll Coordinator within 30 days from your date of hire.
CHANGE IN STATUS
You may change your contribution election at the beginning of the each plan year. You may only change your election during the plan year if you can demonstrate a “change in status.” Only the following events will be considered a valid change in status under Internal Revenue Service rules. <ul style="list-style-type: none">• Change in legal marital status• Change in number of dependents• Change in employment status• Change in work schedule, which changes your eligibility for the program• Dependent satisfies or ceases to satisfy eligibility requirements• Change of residence or worksite• Judgement decree or order pertaining to child or spouse If you would like to terminate your elections as a result of a valid status change, enter a zero dollar amount in the HCSA/DCAP section(s) of the enrollment form. Payroll Coordinators must obtain the appropriate documents for a Change in Status, such as a copy of the marriage or birth certificate.
SIGNATURE AND FORM SUBMISSION
The employee and Payroll Coordinator must sign this form. All forms must be submitted to the Payroll Coordinator at your work site. The Payroll Coordinator must send the original form to Benefit Strategies, LLC.
ELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN
Eligible expenses under a Dependent Care Assistance Plan are defined as those that enable the participant and the participant’s spouse to work or to look for work. They include the following: <ol style="list-style-type: none">1. Child Care centers that care for six or more children and that meet the IRS’ definition of a qualified day care center.2. Caregivers for a disabled spouse or dependent who lives with the participant.3. Babysitters4. Nursery Schools5. Day Camp6. Household expenses, provided that a portion of such expenses are incurred to ensure a qualifying dependent’s well-being and protection. Note: Please see IRS Publication 503 for a list of qualifying dependents. In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19.
INELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN
<ol style="list-style-type: none">1. Babysitting for social events2. Educational Expenses3. Charges for overnight camp
ELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT
Eligible expenses under a HCSA are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program. Eligible expenses are listed in the Participant Handbook available on the GIC’s web site, www.mass.gov/gic . Don’t forget that expenses such as insurance premiums may be deductible on Schedule A tax return, but not eligible for reimbursement through a HCSA. Some examples of eligible expenses are: acupuncture, ambulance, artificial limbs, contact lenses, health plan deductibles, dental fees, health and RX co-pays, hearing aids and more.
INELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT
Certain health care expenses are not eligible for reimbursement from your HCSA, some of which are: cosmetic surgery, cosmetic procedures, fitness programs, hair transplants, health club memberships, and insurance premiums.