2017 Flexible Employees' Benefits Plan Enrollment Form

(Health Care and Dependent Care Reimbursement Accounts)

Return completed form to: Flexible Employees' Benefits Board, PO Box 304900, Montgomery AL 36130-4900
Telephone: (334) 263-8312 Toll Free: 1-866-833-3378 Fax: (334) 263-8512

EMPLOYEE INFORMATION (PLEASE PRINT)

Do you plan to retire in 2017? Yes ☐ If yes, when? _____ No ☐ Undecided ☐

Name:	**Contract or Social Security #**	**Date of Birth**

Address:

City, State and Zip:

Work Phone (required):	**Home Phone:**

Email Address:

If any of the following advisors assisted you, check the box by their name:

☐ **Marsha Abbett** ☐ **Kerry Schlenker** ☐ **Rick Wages**

Health Care Reimbursement Account – for your portion of uninsured medical/dental/vision and prescription expenses and deductibles, for you and your dependents, but not for health insurance premiums. (Minimum annual contribution is $120 and the maximum is $2,550*)
*The Flexible Employees' Benefits Board provides a $50 credit to any member who enrolls in the HCRA. Therefore, if you elect the maximum $2,550, the total contribution to your account will be $2,600.

- To enroll, enter the estimated annual amount you expect to spend for qualifying out-of-pocket healthcare expenses during the plan year (January 1 thru December 31).
- This annual amount will be divided by the number of pay periods you will be working during the plan year. If you are employed the full year, the annual amount will be divided by your total number of pay periods each year and taken out of each paycheck in equal amounts.

HCRA Annual Contribution Amount: _____
(Do not include expenses for over-the-counter items unless approved by ConnectYourCare)
All enrollees will receive a flexible spending card. Please save all receipts.

Dependent Care Reimbursement Account – for dependent/child care related expenses, but not for dependent's medical/dental expenses.

- To enroll, enter the estimated annual amount you expect to spend for qualifying dependent care expenses during the plan year ($5,000 maximum).
- This annual amount will be divided by the number of pay periods you will be working during the plan year (January 1 thru December 31). If you are employed the full year, the annual amount will be divided by your total number of pay periods each year and taken out of each paycheck in equal amounts.

DCRA Annual Contribution Amount: _____

Important – Read Carefully Before Signing

I understand that I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Jan. 1-Dec. 31) unless I have a change in status as defined by the IRS. During the annual open enrollment period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Jan. 1-Dec. 31). I must enroll each year during the open enrollment period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year. Up to $500 of unused funds remaining in the HCRA will "carry over" to the next plan year after the prior year's filing period has expired. Funds in excess of $500 remaining in the HCRA after the prior year's filing period has expired will be forfeited.

I further understand and agree that if I receive payments that exceed the amount of eligible expenses or if I fail to provide proper documentation for a request for reimbursement or validation of a debit card transaction, my flexible spending debit card will be de-activated, I will not be allowed to re-enroll in the plan, and I will be required to repay the excess reimbursement immediately after receipt of notification. If I fail to repay the excess reimbursement immediately, the FEBB is hereby authorized to: (1) offset the excess reimbursement against any other eligible expenses submitted for reimbursement (in accordance with applicable law); or (2) withhold the amount of the excess reimbursement from my pay (to the extent permitted by applicable law). If the FEBB is unable to recoup the amount of the excess reimbursement by any of these means, the amount of the excess reimbursement that could not be recouped will be reported to the Internal Revenue Service and could result in adverse tax consequences to me.

I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Employees' Benefits Plan and all information furnished is true and complete.

Employee Signature: _____ Date: _____