Flexible Benefit Accounts
Enrollment Form

Please print clearly and complete all fields:

Section A: Employer and Employee Information			
Employer Name:		Enrollment Date:	
Employee Name:		Date of Hire:	
SSN:		Home Phone:	
Employee Address:			
City:		State:	Zip:
Email Address:			
Pay Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☑ Monthly ☐ Other:			

Section B: Employee Portion of Group Coverage Premium – medical/dental/vision

Premium Reduction – Employee Group Benefits ☐ Check if you do **NOT** want your premium deductions taken pre-tax

Section C: Flexible Benefit Election

Health FSA Reimbursement Account: (Maximum Annual Election is $3,050) **Effective Date:** 01/01/2024

Pay period withholding ---------- x Number of pay periods 12 **--------- = $---------- Annual Election**

Dependent Care Reimbursement Account: (Maximum Annual Election is $5,000) **Effective Date: ------/-------/----------**

Pay period withholding ---------- x Number of pay periods --------- = $---------- Annual Election

Section D: Benefit Card and Authorization (an email address is required for benefit card communications)

☐ Yes, I would like a Health FSA Benefit Card for myself - *(Benefit Cards will be mailed to the address listed on this form)*

☐ Yes, I would like a Health FSA Benefit Card for my spouse or dependent (Please provide name and SSN below)

Name: SSN:

☐ - Yes, I authorize Verde Services to share my Protected Health Information (PHI) information with:

Name: Relationship:

Section D: Authorization

☐ - Employee Authorization

I have read the Summary Plan Description. I have read and agree to all of the conditions and participation rules on page 2 of this form and authorize my employer to reduce my salary on a per pay period basis. I understand that my election cannot be changed or revoked unless I experience a qualified status change event.

☐ - Employee Waiving Participation

I waive participation in the Flexible Benefit Accounts. I understand that if I waive participation I cannot enter the program until next open enrollment unless I experience a status change in accordance with IRS Section 125 and submit the changes within 30 days of the qualified status change event.

Employee Signature: _____ Date: _____

Instructions to Complete the Flexible Spending Account Enrollment Form

Please print clearly and complete all fields. Missing information may delay your enrollment in the plan, access to the employee web-based self-service site, and/or receipt of benefit card, if applicable.

Section A: EMPLOYER AND EMPLOYEE INFORMATION

1. Complete Employer Name and Enrollment Date. The Enrollment Date is the first day of the plan year for which you are enrolling.
2. Complete Employee Name and contact information.
3. Indicate an email address. (Required to receive log in instructions for employee web-based self-service access) If your plan allows for a benefit card, important information regarding your debit card purchases will be sent to this email address.
4. Indicate how often you receive a paycheck.

Section B: PREMIUM REDUCTIONS

1. This refers to the employee portion of the medical, dental or vision group premium. Premiums will be deducted pre-tax from the employee's paycheck. If you do NOT want your premiums deducted pre-tax and would like the amount taxed check the box.

Section C: BENEFIT ELECTIONS

1. For each Benefit Plan, check the appropriate box if you wish to enroll in the Benefit Plan.
2. Indicate the Benefit Plan contribution amount. You can either:

    a. Indicate a per pay period contribution amount. OR

    b. Indicate a total Annual Election amount. (*IMPORTANT NOTE:* The Total Annual Election will be divided equally between the totals number of pay periods in the plan year and may create an Annual Election that is slightly less than the Total Annual Election indicated).

3. Enter the month, first day of the month and year the election is effective. (Effective date is the same as given in Section A.)
4. No designation is considered a waive
5. See below for a description of the specific Benefit Plan offered:

Health FSA Reimbursement Account – For unreimbursed and/or out-of-pocket medical expenses which can include but is not limited to deductibles, co-pays, and co-insurance, vision, dental, orthodontia, and eligible over- the-counter items. This DOES NOT include insurance premiums

Dependent Care Reimbursement Account –For day care expenses for a qualified dependent. A Qualified dependent is:

- A child under age 13 in your custody whom you claim as a dependent on your tax return
- A spouse who is incapable of self-care
- A dependent who lives with you, such as a child over age 13, parent, sibling, or in-law-who is incapable of self-care, and whom you claim as a dependent on your tax return.

The maximum allowable amount under IRS regulation is $5,000 per calendar year per family or $2,500 per calendar year for married individuals filing single. This limit is regardless of the number of dependents you may have.

Section D: BENEFIT CARD AND AUTHORIZATION

1. Check if you would like a Health FSA Benefit card for yourself. Benefit cards will be mailed to the address listed on the enrollment form.
2. Check if you would like an additional Health FSA Benefit card for your spouse or dependent. Please provide the name and SSN of the person you would like a card issued to. If you need more than one additional card or need it to be mailed to a different address then please attach an additional sheet with that information.
3. Check if you would like to authorize Verde Services to be able to talk about your account with someone other than yourself. Please provide the person's name and relationship to you.

Section E: AUTHORIZATION

1. Read the participation rules below.

Benefit Plan Participation Rules

I understand that reimbursement account eligibility and benefits information is available from my Benefits Coordinator. I authorize payroll deductions for the benefits elections indicated on the Benefit Account Enrollment Form. I must make election changes no later than 30 days after the date a Qualifying Life Event (QLE) occurs if I want to enroll in a reimbursement account or change my reimbursement account elections or amounts and that any requested election change must be consistent and in line with the QLE. I must file all claims eligible for reimbursement by the last day of the Plan Year or Plan Year's Run out Period, in order to utilize any remaining balance from my account(s). Any amounts remaining in my reimbursement account(s) after the end of the Plan Year or Plan Year's Run out Period, may be forfeited.

Employee Waiving Benefits

I waive participation in the Flexible Benefit Accounts. I understand that if I waive participation I cannot enter the program until next open enrollment unless I experience a status change in accordance with IRS Section 125 and submit the changes within 30 days of the qualified status change event.

2. Read the Authorization Section carefully and sign and date the form. Return to completed form to your Benefits Coordinator.