Holston Conference UMC Health Insurance
FSA ANNUAL ENROLLMENT Form

RETURN THE COMPLETED FORM TO HOLSTON CONFERENCE BENEFITS OFFICE

FSA REMINDERS

Health Care Spending Account

- The health care spending account allows you to make pre-tax contributions to an account that may be used to pay for IRS approved health care expenses not covered under a health benefit plan for which you or your dependents for IRS tax purposes are enrolled. Examples of expenses include co-payments, deductibles, glasses and certain over-the-counter (OTC) drugs. A full listing of the eligible expenses can be found in IRS publication 502, Medical and Dental Expenses at www.irs.gov.
- You can contribute up to a maximum of $2,750 annually.

Dependent Care Spending Account

- The dependent care spending account allows you to make pre-tax contributions to an account that may be used to pay for the cost of care for your children under the age of 13 or for any dependent (including your parents) who is mentally or physically incapable of self-care and lives regularly in your household at least eight hours a day while you (or your spouse) work or attend school on a full-time basis.
- Eligible dependent day care includes day care centers, babysitters, or companions.
- You can contribute up to a maximum of $5,000 if you are a single parent or a married couple filing a joint return (combined contributions made by you and your spouse cannot exceed $5,000), or $2,500 per person if you are married and filing separately.
- You should review whether a dependent care FSA or the federal tax credit would be more advantageous for you.

Enrolling in an FSA

- A new FSA enrollment election must be made each year. Participation is voluntary.
- You may contribute to one or both of the FSA's being offered.
- You do not have to be enrolled in the Company's medical/health plan to enroll in a flexible spending account.
- Once made, your election **is irrevocable and cannot be changed** during the Plan Year unless you have a qualifying status change.
- Expenses must be incurred within the current plan year or subsequent grace period or subject to the carryover provisions as permitted by the Plan and required by law.
- You will be issued a benefits debit card for ease of payment of your eligible FSA expenses. The card is valid for those continuous years that you elect to participate in the Company's FSA's up to the expiration date shown on the front of your card. Replacement fees will apply if a new card must be reissued or additional cards are requested. These fees will be deducted from your account.

Effective Date of Coverage

- If you are a new employee, you must make your FSA election and submit this form to Human Resources within 30 days of your eligibility date. Your contributions will become effective with the first pay period following your eligibility date. If you waive coverage at the time of hire, you must wait until the next open enrollment period to elect to participate for the subsequent plan year unless you have a qualifying status change during the plan year.
- If you are enrolling or making an election change mid-year due to a qualifying status change, your election must be received and approved by Human Resources within 30 days of the status change date.
- If you are rehired in the same calendar year after a break in service that is 30 days or less, your previous FSA elections will be reinstated as of your date of hire. If the break in service is longer than 30 days or if you are rehired in a new calendar year, you will make new FSA elections which will become effective as of your rehire date.

Progressive Benefit Solutions, LLC

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FSA/DCA NEW ENROLLMENT or CHANGE FORM (Print clearly – No Abbreviations)

Employer Name				
Last Name	**First Name**	**MI**	**Social Security Number**	
Home Address	**City**	**State**	**Zip**	
Daytime Phone ( )	**Home Phone** ( )	**Date of Hire**	**Date of Birth**	**E-mail**

Enrollment Status:

☐ New Hire ☐ Open Enrollment

☐ Change in Status
Date of Event: _____

You may be permitted to change your FSA election if you have a qualifying status change. To make a change, you must report the change within **30 days** of the event to Human Resources. All changes are subject to Plan Administrator approval.

Only expenses incurred on or after the date of your qualifying status change are eligible for reimbursement under the new election.

If status change, indicate reason:

Flexible Spending Account (FSA)
- ☐ Change in marital status
- ☐ Birth/adoption/placement for adoption of child
- ☐ Death of a dependent
- ☐ Change in dependent's eligibility
- ☐ You/your dependent becomes eligible for Medicare or Medicaid
- ☐ Change in residence/workplace that affects eligibility of healthcare benefits
- ☐ Leave without pay due to military deployment
- ☐ Change in your/spouses employment status that affects eligibility of health care benefits.

Dependent Care Spending Account
- ☐ Your need for dependent care changes
- ☐ Your dependent care provider changes
- ☐ The costs of dependent care increases by more than 10% (and care is not provided by a relative)

Flexible Spending Account (FSA)	**Dependent Care Spending Account (DCA)**	**Qualified Transportation**	**HSA Information**
Used for uninsured eligible health care expenses incurred by you or a covered dependent. Please refer to your benefit information for Plan minimum and maximum contribution amounts. Annual Election Amount $ _____ Per Pay Period Amount $ _____ ☐ Waive Coverage	Used for eligible dependent care expenses incurred so that you and your spouse (if married) can work. Maximum contribution: $5,000 ($2,500 if married filing separately) Annual Election Amount $ _____ Per payroll Amount $ _____ ☐ Waive Coverage	Used for eligible qualified transportation expenses for mass transit and/ or parking: Mass Transit Maximum Monthly = 260 Parking Maximum Monthly = $260 Monthly Election Amount Parking $ _____ Mass Transit $ _____	Are you participating in an HSA? ☐ YES ☐ NO **If Yes, your FSA will be a Limited FSA for Vision & Dental Expenses only.**

Pay Frequency: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

Acknowledge that:

- I authorize my employer to reduce my pay on a pre-tax basis by the total amount of the contribution(s) noted-above.
- I understand that I **cannot change or revoke** my election(s) prior to the end of the Plan Year for which it is in effect unless I experience a Qualifying Status Change as permitted by the Plan and Section 125 of the Internal Revenue Code. Any changes to my election(s) must be filed with and approved by Human Resources within **30 days** of the status change date.
- Any pre-tax elections I have made here will reduce my compensation for Social Security tax purposes, which could reduce my social security benefits slightly.
- Any amounts remaining in my flexible spending account(s) after the end of the plan year, will be **subject to the Plan's specifications** as required by law.
- I understand that my contributions can only be used for the payment of expenses incurred during the plan year for which this agreement is in effect, or the subsequent grace period or subject to the carryover provisions, as permitted by the Plan.
- I understand that I can change my election (s) prior to the end of the plan year for QTA (Qualified Transportation). QTA plans are governed by Section 132 of the Internal Revenue Code. Any changes must be reported to Human Resources within 30 days of the status change.
- All claims submitted for reimbursement are subject to substantiation requirements and I will be required to **retain all itemized receipts/statements and offer them as proof of eligibility** when requested by the Plan Administrator, Claims Administrator (Progressive Benefit Solutions, LLC (PBS)) or the IRS.
- I will not seek reimbursement of claims through my flexible spending account(s) when they are eligible for reimbursement elsewhere.
- I agree to use the benefits debit card for eligible expenses only.
- I understand the benefits debit card will be inactivated if I do not comply with the provisions of the Plan/card or upon termination of employment.
- I am responsible for any fees associated with the benefits debit card, not otherwise paid for by my employer.

Employee Signature: ___ Date: _____