Health/Dependent Care Flexible Spending Accounts-FSA BCBSIL - Enrollment Form

Employer Use Only:
Re-enrollment __ New __ Change __
Effective Date ______________
1st Deduction Date __________
Payroll Mode W B S M Q
Division Code _____________

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer ____

Member Number (i.e. SSN) ____________________

Your Name ____
(Last) (First) (MI)

Address________________________ **City** ____________________ **State** ______ **Zip** __________

☐ *Check if this address is new within last year.* **Date of Birth** _____ / _____ / _____ **Hire Date** _____ / _____ / _____

II. Election Information (Please check the appropriate box to indicate if you wish to enroll, or do not wish to enroll, and sign below.)

☐ Yes, I wish to participate in the flexible spending account plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Reimbursement Account	$_______._____	X	________	=	$_________._____
Dependent Day Care Reimbursement Account (If married, this amount is less than my spouse's earned income)	$_______._____	X	________	=	$_________._____

I understand that:

- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.

III. Authorization for Blue Cross and Blue Shield of Illinois to Disclose Confidential Medical Information

In electing to have claims for reimbursement from my health care spending account automatically submitted, I authorize Blue Cross and Blue Shield of Illinois to disclose information about the medical care, diagnosis, treatment or advice provided to me and/or my dependents including, without limitation, information about AIDS/HIV, mental illness, and/or the use of drugs or alcohol. I understand that this authorization is valid for the plan year to which this waiver applies and may be revoked at any time. I also understand that any information disclosed under this authorization will be made available to me upon request. I further understand that without this authorization my claims and claims for my dependents cannot be automatically submit by Blue Cross and Blue Shield of Illinois for reimbursement from my health care spending account.

☐ Yes, I authorize Blue Cross and Blue Shield of Illinois to disclose confidential medical information.

☐ No, I do not authorize Blue Cross and Blue Shield of Illinois to disclose confidential medical information.

IV. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements. This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement.

A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

Employee Signature ______________________________ ***Date*** ________________