HCRA / DCRA
FLEXIBLE BENEFITS PLAN ELECTION FORM
FOR MEDICAL AND DEPENDENT DAYCARE FSA ELECTIONS

To enroll, complete the following information, sign the form and return it to your Human Resources Representative. PLEASE PRINT OR TYPE

PLAN INFORMATION

GROUP/EMPLOYER NAME: **PLAN YEAR:**

EMPLOYEE INFORMATION

NAME _____ (LAST / FIRST / MI)

DATE OF HIRE *(Required)* _____ (MMDDYY)

SOCIAL SECURITY NUMBER _____

HOME ADDRESS _____ (NUMBER AND STREET / CITY / STATE / ZIP CODE)

DATE OF BIRTH _____ (MMDDYY)

E-MAIL ADDRESS _____

PHONE NUMBER _____

GENDER ❑ M ❑ F

LOCATION/DEPARTMENT _____

PARTICIPANT'S EFFECTIVE PLAN DATE _____ (Only if different than beginning of Plan Year shown above)

DATE OF FIRST PAYROLL DEDUCTION _____ (MMDDYY)

ELECTION INFORMATION

I understand that the rules of the Internal Revenue Code allow me to use part of my salary on a pre-tax basis to purchase one or more of the following qualified benefits.
I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below.

OPTION I	**PREMIUM CONVERSION ACCOUNT (PCA OR POP)** The group insurance premiums you pay through payroll deductions.	AUTOMATIC	No election required. Unless you notify your employer to the contrary, your share of the insurance premiums will automatically be paid with pre-tax dollars.

PLEASE CHECK YOUR ELECTION(S) AND FILL IN AMOUNT IF APPLICABLE

	BENEFIT ELECTION OPTIONS	ELECTION	DEDUCTION		
OPTION II	**HEALTHCARE REIMBURSEMENT ACCOUNT (HCRA)** You can elect up to the maximum amount $2,500	YES ❑ NO ❑	$ _____ PER PAY PERIOD	NO. OF PAYCHECKS (i.e., 12, 26, etc.)	$ _____ ANNUAL
OPTION III	**DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)** Maximum of $5,000 per Plan Year if single parent or if married and filing a joint Tax Return. Maximum of $2,500 if married and filing separately.	YES ❑ NO ❑	$ _____ PER PAY PERIOD	NO. OF PAYCHECKS (i.e., 12, 26, etc.)	$ _____ ANNUAL

PARTICIPANT ELECTION AUTHORIZATION

I have reviewed and understand the terms and conditions on the back of this page and in my company's Summary Plan Description. I understand that I can not change or revoke this election at any time during the Plan Year unless I have a Qualifying Life Event change allowed by my employer (As determined in the plan document and allowed by the IRS). I further acknowledge that **I am responsible for keeping all receipts verifying all eligible expenses claimed under the MGIS Benefits Purchasing card and must submit such receipts to MGIS for claims substantiation upon request**.

CHOOSE ONE:

❑ YES, the benefits of this Plan have been explained to me and I elect to participate as indicated above**. I have read the disclosure on the back of this form and hereby agree to the terms of the disclosure by signing this form.**

❑ NO, I do not want to participate in an HCRA or DCA at this time, but I understand that I will automatically be enrolled in a PCA/POP. I further understand that I will not have another opportunity to enroll in an HCRA or DCA until the next Open Enrollment period unless I have a Qualifying Life Event change.

OPTIONAL:

❑ I would like to request an additional card for my spouse or tax dependent. (**NOTE:** If you already have a card for your spouse or tax dependent, there is no need to request an additional card.)

ADDITIONAL CARDHOLDER NAME _____ DATE OF BIRTH _____ SOC. SEC # _____

PARTICIPANT'S SIGNATURE **X** _____ **DATE**

HR's SIGNATURE **X** _____ **DATE**

SERVICED BY MGIS

Medical Group Insurance Services, Inc. • 1849 W North Temple • Salt Lake City, Utah 84116 • 1.866.937.3539 • Fax 801.990.2401
www.mgis.com/cdh

TERMS AND CONDITIONS

Qualifying Medical Care and Dependent Care Expenses: I understand that reimbursement will be available only for "qualifying medical care expenses" as determined by my company's plan. These expenses must be incurred while I am enrolled in the Plan. I agree to notify the Plan Sponsor or MGIS if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense that is not allowed. If any legal or collection action is necessary to recover funds that should have been repaid to the Plan, I agree to reimburse the plan for any and all expenses, including legal fees, incurred in seeking reimbursement. I attest that I understand claimed medical expenses can not be reimbursed under the Healthcare FSA Plan if the expense has been or will be paid in the future by any other plan and **acknowledge that the medical expenses have not been reimbursed or are not reimbursable under any other insurance plan coverage.** I further acknowledge that I am responsible for keeping all receipts verifying all eligible expenses claimed under the Plan and must submit such receipts to MGIS for claims substantiation, upon request.

Participation Rules: I understand that reimbursement account eligibility, enrollment and benefits information is available from my Plan Sponsor. I authorize payroll deductions for the benefit elections indicated on this Election Form. I understand that I cannot change or revoke this compensation reduction agreement at any time during the Plan Year except for the occurrence of a Qualifying Event as defined by the Plan. In the case of a Qualifying Event, I must complete a Change Form no later than 30 days after the date the Qualifying Event occurs if I want to enroll in a reimbursement account or change my reimbursement account elections or amounts. Any amounts remaining in the account(s) represented by this Election Form at the end of the Plan Year, past the claims filing limit, will be forfeited to the Plan under the guidelines of the Internal Revenue Code.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE PLAN SPONSOR'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

AUTHORIZATION

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a healthcare provider, a health plan, my employer, or a healthcare clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of healthcare to me; or (iii) the past, present, or future payment for the provision of healthcare to me.

Medical Group Insurance Services, Inc. (MGIS) is authorized to use or disclose my protected health information for the purpose of administering my §125 account. **I further authorize MGIS to release my protected health information to my spouse and/or my tax dependent(s). I understand that I may decline disclosure of my protected health information (to my spouse and/or tax dependent/s) by submitting a written notification to MGIS.**

All protected health information pertaining to the reimbursement of a §125 claim may be used and disclosed by MGIS.

I understand that I may revoke this authorization at any time by sending a written notification to MGIS, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that MGIS already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage by MGIS and, by law, MGIS has a right to contest the coverage.

I understand that this authorization expires upon termination of my employer's plan.