LGC NEW HAMPSHIRE
Local Government Center

SAU #66 Hopkinton School District – Support Staff

Flexible Benefits Plan – *Enrollment Form*

First Name_____ Last Name_____ MI_____ Gender_____ Date of Birth_____ Marital Status _____

Social Security #_____ Home Telephone_____ Work Telephone_____ E-mail Address_____

Mailing Address_____ City_____ State_____ Zip_____

Premium Conversion (Pre-Tax Payroll Deduction of Insurance Premiums)

I understand by electing this option, my share of the premium under the plan(s) chosen below will be deducted from my paycheck on a pre-tax basis. I understand that if I do not elect Premium Conversion, my share of the premium under the plan(s) will be deducted from my paycheck on an after-tax basis. I also understand that if my premium obligation increases or decreases during the Plan Year, my salary reduction will be adjusted automatically. The amount(s) of my required premium contribution for each plan has been provided to me by my employer in other plan materials. ❑ **I hereby elect to participate in Premium Conversion for the following plans (check all that apply): ❑ Medical ❑ Dental**

Cash Opt-Out

I understand that by electing this option, I am accepting cash in lieu of participation in the following plans (check all that apply). I understand that this cash benefit is subject to federal income plus FICA and Social Security taxes, and that I won't be eligible to receive benefits under any of the plans for which I elect the cash opt-out. The amount(s) of this cash benefit has been provided to me by my employer in other plan materials.

❑ **I hereby elect the Cash Opt-out benefit in lieu of participation in the following plan: ❑ Medical**

Healthcare Flexible Spending Account Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible healthcare expenses that have not been reimbursed under any other plan.

❑ I do ❑ I do not want to participate in the Healthcare Flexible Spending Account. $_____ X _____ = $_____
Per Pay Period Election Amount # of Pay Periods Total Employee Election

Minimum Contribution Amount $ 400 Maximum Contribution Amount $ 2,500 Employer Contribution Amount $_____

Dependent Care Reimbursement Account Election

I understand that by electing this option, my election amount will be deducted from my paycheck on a pre-tax basis in equal installments throughout the plan year, and this account will only reimburse IRS-eligible dependent care expenses that have not been reimbursed under any other plan. I understand that the IRS requires disclosure of a Tax ID or the Social Security number of my daycare provider on my income tax filing and when applying for reimbursement from my Dependent Care Reimbursement Account.

❑ I do ❑ I do not want to participate in the Dependent Care Reimbursement Account. $_____ X _____ = $_____
Per Pay Period Election Amount # of Pay Periods Total Election Amount

Minimum Contribution Amount $ 400 Maximum Contribution Amount $ 5,000

Salary Reduction Agreement and Signature

I also understand and agree to the following:

- The total amount(s) stated above will be deducted from my paychecks on a pre-tax basis in equal installments throughout the Plan Year. I understand that this will lower my gross pay and, consequently, Social Security earnings for tax purposes.
- My elections, including any above stated salary reduction amount(s), must remain in effect until the end of the Plan Year or my employment termination date, whichever occurs first. However, in the event of a change in my family or employment status (i.e. marriage, divorce, birth, paid or unpaid leave of absence, change in hours, etc.), I may be allowed to change or revoke my election(s) and salary reduction amount(s) in accordance with plan rules.
- I will be obligated to re-pay any mistaken payments I receive from the Plan in accordance with the Plan terms.
- IRS regulations stipulate a "use-or-lose" rule that requires employees to use all of their designated Healthcare FSA or Dependent Care Reimbursement Account funds during the plan year (or during the 2½ month grace period immediately following the plan year if elected by your employer) or forfeit remaining balances.
- My Healthcare Flexible Spending Account will reimburse IRS-eligible healthcare expenses up to my annual election amount (minus any previous payment). I understand that I (or my spouse if applicable) cannot make contributions to a Health Savings Account (HSA) if covered by the Healthcare FSA.
- My Dependent Care Reimbursement Account will reimburse IRS-eligible dependent care expenses only up to my account balance at the time of my request.

Employee Signature _____ **Date** _____

Employer Information

Annual Open Enrollment _____ OR New Hire _____	If New Hire Date of Hire _____ Effective Date _____	Payroll Calendar: 10-month (21 pays) _____ 10-month (26 pays) _____ 12-month (26 pays) _____

SAU #66 Hopkinton School District – Support Staff

Flexible Benefits Plan – *Debit Card Enrollment Form*

First Name _____ Last Name _____ MI _____

The *Benny™ Prepaid Visa® Card* is a debit card option that is part of the Healthcare Flexible Spending Account (FSA) or Dependent Care Reimbursement Account. Employees participating in the Healthcare FSA or Dependent Care Reimbursement Account may elect to use debit cards to obtain direct reimbursement of Qualifying Expenses, subject to applicable substantiation requirements. If I don't elect a debit card, I will submit a Reimbursement Form to request reimbursement.

❑ **I do** ❑ **I do not** want a debit card.

❑ **I already have a debit card and want to continue using it in the new Plan Year.**

Required Receipt Information

All charges made to the Card are only *conditionally reimbursed* until related receipts are received and approved by LGC per Internal Revenue Service (IRS) regulations. Documentation of the expense* should be submitted to LGC within **14 days** of using the Card to pay for an approved FSA expense. This can be in the form of a bill, receipt of payment (from provider or insurer), explanation of benefits or a written statement from an independent, third party noting the service incurred and its expense amount.

*Documentation is not required if the expense equals the co-payment amount required by 1) your employer's medical plan for a doctor's office visit, or 2) your employer's pharmacy plan for a prescription. Also, the IRS requires that the Card work only at discount stores, department stores and supermarkets that can identify FSA-eligible items at checkout; therefore, documentation of those purchases is not required.

All receipts submitted to LGC should include the following IRS-required information:

- Name and address of service provider
- Date service and expense were incurred
- Name of person receiving the service
- Detailed description of service provided
- Amount charged for service

Credit card slips from *Benny™ Prepaid Benefits Card* transactions cannot be submitted as receipts because they typically do not include all of the information noted above. Also, if your employer allows over-the-counter items to be covered under your FSA plan, receipts must have each item's name printed on them; handwritten item names are not acceptable.

Debit Card Agreement and Signature

I also understand and agree to the following:

- If my card is lost or stolen and I request a replacement card, I am authorizing a fee of $5 to be debited from my account.
- I certify that the debit card will only be used to pay for IRS-eligible healthcare and/or dependent care expenses that have not been reimbursed under any other plan.
- I understand that I am required to submit paper substantiation for all expenses charged to the debit card unless otherwise permitted by the FSA Administrator in accordance with applicable IRS rules.
- I understand that the debit card can only be used during the current Plan Year and cannot be used in any applicable grace periods.
- I understand and agree that misuse of the debit card will result in permanent revocation of the card and I will be obligated to repay any ineligible expenses that have been reimbursed.

Employee Signature _____ **Date** _____

Be sure to attach this form to the Flexible Benefits Plan Enrollment Form