ENROLLMENT APPLICATION
FLEXIBLE SPENDING ACCOUNTS

1. EMPLOYEE INFORMATION

Last Name First Name MI

Address City, State, Zip

Employer ID #/SS # Phone DOB

Email Address - By providing an email address, you agree information pertaining to your account can be emailed to the address provided.

2. EMPLOYEE STATUS

( ) New enrollee effective _________________ ( ) Annual election effective _________________

❑ Yes, I would like a Flex debit card for the plan year. (An annual fee will be deducted from my medical spending account balance.)

❑ No, I do not want a Flex debit card for this plan year.

3. PRE-TAX PREMIUM PAYMENT AGREEMENT

❑ I agree to have my gross salary redirected, in accordance with Section 125 of the Internal Revenue Code, to pay my premiums for employer sponsored benefits I elect which are payable through the flexible benefits plan. I understand if my required premium contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted.

❑ I elect not to participate in this option.

4. EMPLOYEE SPENDING ACCOUNT AGREEMENT

❑ I agree to have my gross salary redirected, in accordance with Section 125 of the Internal Revenue Code, to contribute in the amounts indicated below. I understand that contributions to my spending account(s) can only be reimbursed to me for eligible expenses incurred within each plan year. For example, funds in the Medical Spending Account cannot be used for reimbursement of dependent care expenses. I further understand that if I do not use the funds in my spending account(s) during the plan year, those funds may be forfeited based on the specifications of my employer's plan. Please see your summary plan description for plan details.

- Medical Spending Account $ ________ (Per Pay) x ________ (Pays/Year) = $ ________ (Plan Year Election)
- Dependent Care Spending Account $ ________ (Per Pay) x ________ (Pays/Year) = $ ________ (Plan Year Election)

  (Maximum Annual $5,000 if single or married or $2,500 if married filing a separate return.)
- Health Savings Account $ ________ (Per Pay) x ________ (Pays/Year) = $ ________ (Plan Year Election)
- Limited Medical Spending Account $ ________ (Per Pay) x ________ (Pays/Year) = $ ________ (Plan Year Election)

❑ I elect not to participate. – (Skip to Section 7)

5. DIRECT DEPOSIT AUTHORIZATION OF REIMBURSEMENT CLAIMS

I hereby authorize **DASFLEX** to initiate credit entries to my: ❑ Checking Account ❑ Savings Account

Account Number: ________________ Bank Routing Number: ________________

Financial Institution: ________________ City: ____________ State: ______

This authority will remain in full force and effect until **DASFLEX** has received written notification from me of its termination, in such time and in such manner as to afford **DASFLEX** a reasonable opportunity to act on it. **DASFLEX** is not responsible for any bank fees related to expenditures made before an actual ACH deposit is in your account. It is your responsibility to verify that the funds are in your account before you expend them.

For verification, please attach voided check to this application.

6. AUTOMATIC PROCESSING - CLAIMS *NOT ELIGIBLE IF ELECTING DEBIT CARD OPTION*

_____ I DO wish to have my requests for reimbursement processed automatically through **DASFLEX**.

In the event a claim is submitted through Avera Health Plans, DAKOTACARE, or DAKOTACARE Administrative Services, Inc. (DAS), I understand the claim Explanation of Benefits will automatically be submitted to **DASFLEX** for processing from my Flexible Spending Account. I further understand and certify that the expenses were incurred by me (and/or spouse and/or eligible dependents) and were/will not be reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my **DASFLEX** account. I will not use the expense reimbursed through **DASFLEX** as deductions or credit when filing my (our) individual income tax return. If audited, I understand that it is my responsibility (not my employers) to provide written proof that these expenses were actually incurred and eligible for reimbursement. Also, if you elect this option you cannot have a debit card

If you are contributing to a health savings account or limited medical spending account or if you are covered under another health insurance plan, you are not eligible to elect this option.

_____ I DO NOT wish to have my requests for reimbursement processed automatically through **DASFLEX**.

INTERNAL REVENUE CODE REGULATIONS

- **GENERAL PROVISIONS:**
  - **DASFLEX** elections cannot be changed during the plan year unless there is a "status" change such as marriage, divorce, birth, adoption, death, change in spouse's employment, or other qualifying events.
  - Expenses paid through your spending accounts are no longer eligible as personal deductions on your income taxes. Only those expenses which are deductible for Federal Income Tax purposes and which have not been reimbursed by any other plan are eligible for reimbursement.
  - If enrolled in the Dependent Care Expense Account, the amount of expense eligible for your Dependent Care Tax Credit will be reduced, dollar for dollar, by amounts reimbursed from that account.
  - You agree to indemnify and reimburse your employer on demand for any liabilities that may occur from any reimbursement made for a non-qualifying expense.
- **SOCIAL SECURITY/WORKERS' COMPENSATION BENEFIT REDUCTIONS:**
  - Since **DASFLEX** elections reduce your wage base for social security and workers' compensation contributions, your death, disability, retirement, and survivor benefits from those programs will likely be reduced.
  - You agree that your employer, the plan coordinator, and the plan administrator will not be held liable for any social security or workers' compensation benefit reductions which may result from your participation in **DASFLEX**.
  - I, the undersigned, have read and agree to comply with the INTERNAL REVENUE CODE REGULATIONS on this application.

7. EMPLOYEE SIGNATURE	8. DATE
X	