ENROLLMENT FORM
FLEXIBLE SPENDING ACCOUNTS

(*PLEASE PRINT CLEARLY*)

Benefit Resource, Inc.
plans that perform
2320 Brighton-Henrietta Townline Rd
Rochester, NY 14623
Phone: (800) 473-9595
Website: www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time

Email Address: ____

(Note: Benefit Resource will only use your email address to communicate with you regarding your Plan.)

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with Section 125 of the Internal Revenue Code.

B. FLEXIBLE SPENDING ACCOUNTS *Please enter your FSA election(s).*

(Refer to your Plan Highlights for election maximums)	**Per Pay Deduction**	**Plan Year Election**
☐ Medical Flexible Spending Account	$ ______________	$ ______________
☐ Dependent Care Flexible Spending Account	$ ______________	$ ______________

C. EMPLOYEE CERTIFICATION

I have received and read the printed material which explains my Plan and my options under it. I understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current Plan Year. Any choices above may be modified only as defined in the Plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® MasterCard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal MasterCard by a bank chosen by Benefit Resource. I agree to use this card only for eligible medical expenses under the Plan for me or a qualifying individual and to be bound by all provisions of the Beniversal *Cardholder Agreement* and *My Beniversal Use of Card Promises* sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the *Agreement*, I may lose Beniversal Card privileges and will reimburse the Plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper follow-up requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such follow-up documentation to Benefit Resource upon request.

Signature: ____ Date: _____ / _____ / _____

D. PAYROLL DEDUCTION INFORMATION *Employer must complete this section for employee to be enrolled.*

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other ____________________________________
- **Pay Date of first FSA deduction(s):** _____/_____/_____
- **Number of pay dates on which FSA deduction(s) will be taken during this Plan Year:** ____
- **Health Insurance Coverage Code:** ___ ___ ___ ___ ___ ___ ***This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.***

Please return completed form to your employer.

The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.