FSA Enrollment Form

PLEASE PRINT CLEARLY TO ENSURE ACCURATE ENROLLMENT AND FUTURE COMMUNICATION.

Employer Name: ______________________________

Participant Name:______________________________Social Security #: ______________

Address: ______________________________

City:______________________________State:__________Zip: ______________

Phone Number:______________________________Birthdate: ______________

E-mail Address:______________________________(Notification of direct deposit payments are only sent via e-mail)

Pay Period: ☐ Weekly ☐ Semi-Monthly (twice a month) ☐ Bi-Weekly (every other week) ☐ Monthly

MEDICAL REIMBURSEMENT ACCOUNT

☐ I elect to participate $____________annually (may not exceed employer limit of $ 2750 ________)
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

☐ This Medical Reimbursement Account is a Limited Purpose Account for HSA eligibility (see page 2)

DEPENDENT CARE ACCOUNT

☐ I elect to participate $____________annually (may not exceed $5000 or $2500 if married filing separately)
Annual election will be divided by the number of pay periods in the plan year or the remaining number of pays for mid-year enrollments

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year may be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature______________________________ Date ______________

FOR HR/PAYROLL USE ONLY

Bi-Weekly Payroll Deduction beginning ______________________

Medical FSA: $______________ Limited FSA: $______________ Dependent Care FSA $:______________

MEDICAL FSA ELECTION WORKSHEET

EXPENSE	ESTIMATED COST
MEDICAL*	
Acupuncture	$
Chiropractor	$
Podiatrist	$
Deductible	$
Co-pays	$
Doctor fees	$
Office visit	$
Prescriptions	$
Hospital bills	$
Laboratory fees	$
Medic alert bracelet	$
Dermatologist	$
Immunizations	$
Obstetrical expenses	$
Routine physicals	$
X-rays	$
Well baby checkups	$
HEARING*	
Hearing exam	$
Hearing aids	$
Special batteries	$
VISION*	
Glasses	$
Eye exam	$
Contact lenses	$
Contact lens solution	$
Prescription sunglasses	$
LASIK surgery	$
Visine and eye drops	$
Reading glasses	
DENTAL*	
Orthodontic	$
Dentures/bridge/ crowns	$
Fluoride treatments & seals	$
Cleanings and fillings	$
Root canals	$
Extractions	$
COLUMN #1 TOTAL	$

EXPENSE	ESTIMATED COST
OVER-THE-COUNTER ITEMS*	
Acid controllers	$
Acne medication	$
Antibiotic products	$
Anti-diarrheas/gas	$
Anti-itch/insect bite	$
Antiparasitic treatments	$
Baby rash creams	$
Band-aids	$
Carpal tunnel wrist supports	$
Cold sore remedies	$
Cold/hot packs for injuries	$
Cough, cold & flu	$
Digestive aids	$
Feminine anti-fungal / anti-itch	$
Hemorrhoidal preps	$
Home pregnancy tests	$
Incontinence s upplies	$
Laxatives	$
Liquid adhesive for small cuts	$
Nasal strips	$
Pain relief	$
Sleep aids & sedatives	$
Stomach remedies	$
Stop smoking programs/items	$
Sunscreen	$
MENSTRUAL PRODUCTS*	
Tampons	
Pads and liners	
Menstrual cups	
BIRTH CONTROL DEVICES*	
Condoms	$
Prescriptions	$
Sterilization	$
COLUMN #2 TOTAL	$

EXPENSE	ESTIMATED COST
DIABETIC SUPPLIES*	
Insulin	$
Glucometer	$
Syringes/Needles	$
Test Strips	$
THERAPY*	
Physical therapy	$
Learning disability	$
Psychologist fees for medical care	$
Psychiatric care	$
PHYSICAL IMPAIRMENTS*	
Wheelchair	$
Crutches	$
Walker	$
Custom made orthopedic shoes and inserts	$
SPECIAL NEEDS*	
Transportation to and from doctor/ hospital (call for current mileage rates and guidelines)	$
COLUMN #3 TOTAL	$

EXAMPLES OF INELIGIBLE EXPENSES

The IRS does not allow reimbursement for the following:

- Cosmetic surgery
- Insurance premiums
- Marriage/debt counseling
- Eyeglass sun clips
- Eyeglass or contact warranty
- Prepayment of services
- Special (dietary) foods
- Personal care items
- Diapers
- Deodorant
- Chapstick
- Face cream or moisturizers
- Teeth bleaching/whitening
- Tooth brushes/toothpaste
- Floss/flossing devices

EXPENSES THAT REQUIRE A LETTER OF MEDICAL NECESSITY

The IRS allows reimbursement of the following with a copy of the physician's statement of medical necessity that includes the specific product/service and a diagnosis. Treatment cannot be for general health or well being. A copy needs to be submitted with every reimbursement request and a new letter needs to be reinstated every 12 months.

EXPENSE	ESTIMATED COST
Health club fees/ gym memberships	$
Nutritional supplements/vita-mins	$
Massage therapy	$
Weight loss programs (i.e. Weight Watchers and Jenny Craig) - Program fees are eligible but food portions are not.	$
COLUMN #4 TOTAL	$

ESTIMATED EXPENSES

COLUMN 1	$
COLUMN 2	$
COLUMN 3	
COLUMN 4	$
TOTAL ESTIMATED EXPENSES	$

* Please note: This list is a broad overview of eligible expenses; not all services provided by a provider or practitioner are eligible under the IRS regulations. Please call BASIC regarding your specific item or treatment to confirm eligibility.

You may also want to review the IRS Publication 502 for Medical Expenses for additional examples.

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