benefit strategies LLC

CITY OF WATERBURY, CT
FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

A. Employee Information

Please Print Clearly!

Name: _____ **Social Security Number (Required):** _____

Home Address:
Check If New: ☐ _____

City: _____ **State:** _____ **Zip Code:** _____ **Day Phone:** _____

E-mail Address: _____ **Date of Birth:** _____

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Reimbursement Account Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

$	X		=	$	Election allowed $100 minimum/$2,650 maximum
Your Contribution Per Pay Period		# of Pay Periods		Total Election	

2. Dependent Care Assistance Account Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

$	X		=	$	Election allowed $100 minimum/$5,000 maximum ($2,500 if married filing separately)
Your Contribution Per Pay Period		# of Pay Periods		Total Election	

C. *FlexExpress*© Debit Card

The FlexExpress Cards are optional. If you and/or your dependents have debit cards, they will automatically be reactivated unless you indicate below that you do not want cards. Otherwise, please indicate your selection below. Annual Fees: Paid by Employee, Cost $5 per set.

Check One:		***If you and/or your dependents have debit cards, they will be automatically reactivated for your renewal. Otherwise, please select from below:***	NO action required.
	☐	I am a new participant to this plan and would like a NEW set of debit cards.	This is for brand new participants only; You will receive 2 cards. If you already have cards, selecting this option will automatically inactivate your existing cards.
	☐	I have cards that were lost, stolen or damaged and would like a replacement set of cards.	Selecting this option will inactivate and replace all of your existing cards. Replacement cards are $5 per set.
	☐	I do NOT want FlexExpress Cards.	Your default reimbursement method will be check unless the direct deposit information below is completed.

Additional Card Information: Please indicate the number of additional cards you would like to receive below (If you request a card for yourself you will get 2 to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.) Additional sets are $5 per set.

Number of Additional Sets Requested:

D. Direct Deposit Authorization

If you would like non-debit card reimbursements to be direct deposited to your bank account (rather than receiving paper checks) fill out the information below EACH PLAN YEAR AND attach a voided check. If you do not complete this information each plan year you will be defaulted to check.

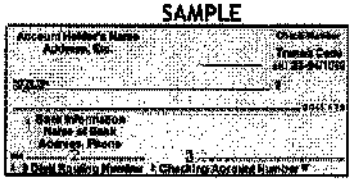
Bank Name:
(See #1 on sample)

☐ Checking Account
☐ Savings Account

Routing Number - 9 digits (See #2 on sample):

Account Number (See #3 on sample): _____

SAMPLE



E. Signatures

By signing below I agree to the following terms and conditions:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my reimbursement account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back.
- For expenses reimbursed through this account, I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
- The IRS requires me to keep documentation of all my expenses claimed and supply them to Benefit Strategies if requested.
- I have read and understood all of the plan details outlined in my Summary Plan Description.

Employee Signature (required):		**Date:**	
Employer Acceptance (required):		**Benefit Effective Date:**	
*If this is a mid-year enrollment, please list the first payroll date for deductions.		**First Payroll Date:**	

benefit strategies LLC

CITY OF WATERBURY, CT
LIMITED PURPOSE FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

A. Employee Information *Please Print Clearly!* Instructions on Back

Name: _____ **Social Security Number (Required):** _____

Home Address:
Check if New: ☐ _____

City: _____ **State:** _____ **Zip Code:** _____ **Day Phone:** _____

E-mail Address (Required): _____ **Date of Birth:** _____

B. Flexible Benefit Plan Pre-tax Elections

1. Limited Purpose Health Care Account Eligible expenses include professional dental and vision expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body".

$	X		=	$
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Election Allowed
$100 Minimum / $2,650 Maximum

2. Dependent Care Assistance Account Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

$	X		=	$
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Maximum Election Allowed
$100 Minimum / $5,000 Maximum
($2,500 if married filing separately)

C. *FlexExpress*© Debit Card If you are a new enrollee a set of 2 FlexExpress Cards will be mailed out to you automatically. If you and/or your dependents already have debit cards, they will automatically be reactivated. Otherwise, please indicate your selection below.

Check One:	***If you and/or your dependents have debit cards, they will be automatically reactivated for your renewal. Otherwise, please select from below:***	NO action required.
	☐ I have cards that were lost, stolen or damaged and would like a replacement set of cards.	Selecting this option will inactivate and replace all of your existing cards. Replacement fee is no charge.

Additional Card Information: Please indicate the number of *additional* cards you would like to request below. If you request a card for yourself you will get 2 to start. Please note that cards are ordered in multiples of 2. (Examples: 2, 4, 6, 8, etc.)

Number of Additional Sets Requested:

D. Direct Deposit Authorization If you would like your debit card reimbursements to be directly deposited to your bank account (rather than receive paper checks), fill out the information below EACH PLAN YEAR AND attach a voided check. If you do not complete this information each plan year, you will be defaulted to check.

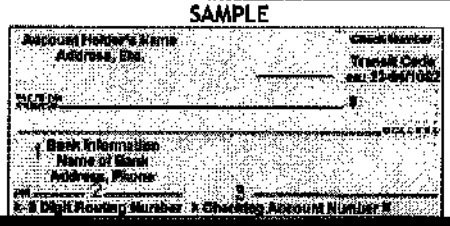
Bank Name:
(See #1 on sample)

☐ Checking Account
☐ Savings Account

Routing Number - 9 digits (See #2 on sample):

Account Number (See #3 on sample): _____

SAMPLE



E. Signatures By signing below, I agree to the following terms and conditions:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year.
- I understand that my employer may allow me to carryover unused funds up to plan limits at the end of the plan year for deposit into the next following plan year for future use. Any money unclaimed from my Health Care Reimbursement Account(s) at the end of the Plan Year in excess of the carryover limits will be forfeited to my employer after a run-out period. I will not receive it back.
- For expenses reimbursed through this account I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
- The IRS requires me to keep documentation of all my expenses claimed and supply them to Benefit Strategies if requested.
- I have read and understood all of the plan details outlined in my Summary Plan Description.

Employee Signature (required):		**Date:**	
Employer Acceptance (required):		**Effective Date:**	
*If this is a mid-year enrollment, please list the first payroll date for deductions.		**First Payroll Date:**	