



1975 Tamarack Road P.O. Box 1096
Newark, OH 43058-1096 (800) 297-1829

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer or health benefit plan, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

FLEXIBLE SPENDING PLAN (FSA) COMPENSATION REDIRECTION AGREEMENT

PLEASE READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR PARTICIPATION FROM BEING DELAYED

Employee Information (Please Print in Ink):

Name _____ Social Security Number _____
Last First Middle Initial

Home Address _____ Telephone () _____
Street City State Zip

Employee Date of Birth ___/___/___ Mo. Day Yr.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Date Hired ___/___/___ Mo. Day Yr.
Payroll Cycle <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly		First Pay Cycle Deduction(s) will be taken ___/___/___ Mo. Day Yr.	Effective Date on FSA Plan ___/___/___ Mo. Day Yr.

Employed by _____
Company Name Group/Account Number

LIST DEPENDENTS WHOM YOU WILL BE CLAIMING EXPENSES FOR BELOW

Full Name	Date of Birth	Sex		S.S. Number (Spouse Only)					You &/or your Spouse provide over 50% of Support? Yes / No	Full-Time Student? (Y/N)
		Male	Female							
Spouse										
Other Dependent(s)										

*Are you (Employee) covered or insured under any other medical or dental coverage (including Medicare and other government plans)?
 Yes No If yes, please indicate who the carrier is: _____

*Is your Spouse covered or insured under any other medical or dental coverage (including Medicare and other government plans)?
 Yes No If yes, please indicate who the carrier is: _____

*Are your Dependents covered or insured under any other medical or dental coverage (including Medicare and other government plans)?
 Yes No If yes, please indicate which dependents are covered and who the carrier is: _____

PLEASE BE SURE TO COMPLETE THE BACK OF THIS FORM TO PREVENT A DELAY IN PROCESSING YOUR ENROLLMENT

HEALTH CARE SPENDING ACCOUNT (Employee and/or Dependent Medical, Dental, Eye Care Expenses - not reimbursed by Insurance)

Per Pay Contribution \$ _____

Total Annual Contribution \$ _____
(\$ _____ Maximum)

DEPENDENT CARE SPENDING ACCOUNT (ONLY work-related child and/or Adult Day Care Expenses)

Per Pay Contribution \$ _____

Total Annual Contribution \$ _____
(\$5,000 Maximum; \$2,500 if married and filing separate income tax return)

DECLINE PARTICIPATION IN THE PRE-TAX CONTRIBUTION

DO NOT CHECK THIS BOX IF YOU HAVE COMPLETED THE ABOVE.

WAIVE Election - I hereby elect NOT to participate in the pre-tax benefit option. I understand I will not have another opportunity to enroll until the next annual enrollment period.

Employee Signature _____ Date _____

Read this Statement and Authorization Carefully

I agree that my Compensation will be reduced by the amount of my required contribution for the Benefits that I have elected under the Plan and that such Compensation Redirections will continue for each pay period until this Agreement is amended or terminated. I understand the following:

- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred within the same year **will be forfeited** in accordance with IRS regulations.
- I understand that I cannot change or revoke this Election once the Plan Year has begun unless I have an IRS qualifying change in status.

Qualifying change in status events must be submitted to the Human Resource Department within the first thirty (30) days of the date of the event. A photographic copy of this authorization shall be as valid as the original. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent above.

Employee Signature _____ Date _____