RHI

STATE OF RHODE ISLAND

FLEXIBLE SPENDING ARRANGEMENT ENROLLMENT FORM

FOR PLAN YEAR JULY 1, 2015 *through* JUNE 30, 2016

Section I – Employee Information

Last Name, First Name _____ Employee SSN ____-____-____

Address _____ City _____ St _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email _____ DOB (MM-DD-YYYY) _____

Payroll Account # _____ Agency _____ DOH (MM-DD-YYYY) _____

If outside open enrollment:

_____
Effective Date

Section II – Elections

Benefit	Yes/No	Annual Election	# Paychecks	Paycheck Deduction
Health Care FSA Maximum of $2,550.00 per plan year	❑ Yes ❑ No	$_____ per plan year	**26**	$_____ per paycheck
Flexi-Card A debit card that pays for your expenses from the Health Care FSA	Automatic	**You must provide a valid email address to receive the Flexi-Card.**		
Day Care FSA Maximum of $5,000.00 per plan year ($2,500 if married, filing separately)	❑ Yes ❑ No	$_____ per plan year	**26**	$_____ per paycheck
Direct Deposit Reimbursements are electronically deposited into your bank account.	❑ Yes ❑ No	❑ Checking ❑ Savings	**Routing #**_____ **Account #**_____	

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above. In addition, I understand that my social security benefits may be slightly reduced because I will pay less social security taxes.

Section III – Signature

❑ YES, I elect to participate as indicated.

❑ NO, I decline participation.

X _____ _____
Employee Signature **Date**

Completed enrollment form must be returned to:

State of Rhode Island
Department of Administration
Office of Employee Benefits
One Capitol Hill
Providence, RI 02908-5860
Office: (401) 222-3160
Fax: (401) 222-2964

Please see the reverse for important information regarding the above benefits.

Additional Information

- **Health Care Flexible Spending Arrangement ("Health Care FSA"):**
  - Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document available at www.employeeebenefits.ri.gov and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
  - Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA. Therefore, do not include the cost of premiums in your FSA annual election amount.
- **Day Care Flexible Spending Arrangement ("Day Care FSA")**
  - Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
  - Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse is a full-time student, please consult IRS Publication 503.
- **Use-It or Lose-It**
  - You must claim all elected funds by the end of the run-out period. Money left in the plan after the end of the run-out period cannot be refunded to you; this is referred to as the Use-it or Lose-it rule. Unused health FSA balances up to $500 will be rolled over to the subsequent plan year.

Lost Checks and Reissues

- Lost or stale dated FSA checks can be reissued 10 business days after the original check date. There is a $25.00 check reissue fee. The check reissue request will require at least one business day to process.
- Any fees associated with presenting a canceled check will be deducted from your FSA as well as the face value of the check.

Direct Deposit

- All electronic funds transfers (EFT) will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information will be assessed a $10.00 fee that will be deducted from your FSA balance.

Deductions

- FSA deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form.

Change in Status

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.
- In the event of a change in status the change in election must be necessitated by and consistent with the change in status and the change must be acceptable under IRS Regulations.

Eligibility

- It is your responsibility to determine your eligibility.
- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

Ineligible Flexi-Card Expenses

- The IRS provides the following 2 methods for correcting the reimbursement of an ineligible Flexi-Card Charge. A participant must: a) repay the plan for the amount of the ineligible expense, or b) request the substitution or offset of future claims to repay the plan.
- For example, if you use the card for an ineligible expense the card will be suspended to prevent further use. We will reactivate the card once you reimburse the plan for the amount of the ineligible expense. If you do not reimburse the plan the card will remain suspended. You may still submit claims via fax or mail and, upon request; we will substitute or offset those future claims against the amount of the ineligible expense until the amount of the ineligible expense is repaid. If you do not repay the plan or substitute or offset future claims against the amount of the ineligible expense your employer may take corrective actions consistent with applicable federal or state law.

Lost or Stolen Flexi-Card

- Participant will be charged $5.00 for the reissue of any lost, stolen, or otherwise misplaced Flexi-Card. The fee will be deducted from the participant's Health Care FSA.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Flex-Plan, agents, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at anytime at no cost. To withdraw consent, please contact Flex-Plan.
- You have a right to receive a paper version of an electronically furnished document at no cost.
- To access documents you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.