Flexible Spending Account with Debit Card

MVP HEALTH CARE

Enrollment or Change Request

Need help completing this form? Call 1-888-222-9931 for assistance.

Employer Name | Plan Year Start Date

CHECK ONE X

☐ **Regular Annual Election**

☐ **Mid-Year Election** Effective date: Date of first payroll deduction:

☐ **Change in Family Status** Date of event Date of first payroll deduction after change:

- ☐ Divorce/separation
- ☐ Death of spouse or child
- ☐ Change in work hours
- ☐ Marriage
- ☐ Spouse became unemployed
- ☐ Unpaid leave of absence
- ☐ Birth or adoption of a child
- ☐ Spouse ceases to be employed
- ☐ Other (explain):

EMPLOYEE INFORMATION (PLEASE PRINT)

Employee Name *(Last. First, MI)* Date of Birth / /

Street Address Social Security No.

City State Zip Code Telephone *(Main)*

Email Telephone *(Cell)*

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced | Payroll Cycle ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Bi-monthly

FAMILY MEMBERS ASSOCIATED WITH THIS FLEXIBLE SPENDING ACCOUNT (FSA)

☐ Spouse ☐ Dependent Name Social Security No. Date of Birth ☐ Request Debit Card for this individual

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ENROLLMENT AND REIMBURSEMENT ACCOUNT ELECTION

I authorize my employer to deduct pre-tax contributions from my compensation for the following benefits:	ANNUAL PRE-TAX DEDUCTION ELECTION	*TO BE COMPLETED BY EMPLOYER HUMAN RESOURCES DEPT.* DATE OF FIRST PAYROLL DEDUCTION	PER PAY PERIOD PRE-TAX DEDUCTION
☐ Medical Reimbursement Account *(Reimbursement for family health care expenses not paid from any other source)*	$		$
☐ Dependent Care Reimbursement Account* *(Reimbursement for day care expenses for eligible dependents. Please see back for eligibility restrictions)*	$		$

If you are married and file federal income taxes jointly, the maximum annual dependent care contribution amount is $5,000. If you are single, or are married and file separate tax returns, the maximum annual dependent care contribution amount allowed is $2,500. Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.

☐ *Yes*, I would like to receive reimbursements through direct deposit to a checking or savings account.
(If selecting this option, please complete the *Direct Deposit Authorization for MVP Flexible Savings Accounts and/or Health Reimbursement Arrangements* form and return it to MVP with this form. You can obtain the form from your Employer or by emailing myspendingaccounts@mvphealthcare.com.)

☐ I have read and agree to the *Employee Authorization of Participation* on page 2 of this form.

Employee Name (print) *Signature* *Date*

Employer Human Resources Representative Name (print) *Signature* *Date*

Continued on page 2

Employee Authorization of Participation

By signing on page 1 of this form, I authorize my employer to reduce my pay on a per pay period basis as indicated on page 1. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

I understand that upon enrollment I will receive an MVP CareFund Debit Card and I agree that this card is only to be used to pay for qualified medical expenses that will not be reimbursed from another source, and that I am still responsible to acquire and retain documentation to substantiate any expenses paid for with the MVP CareFund Debit Card. All dependents must be age 18 or over to receive the MVP CareFund Debit Card. Debit cards will be mailed to your home address in a plain envelope. If you previously added a dependent, they will automatically be linked to the plan each year. It is your responsibility to notify the plan once a dependent is no longer eligible or if you with to terminate them from the plan.

Return this completed form by mail to: ATTN: MVP ANCILLARY SERVICES
MVP HEALTH CARE PO BOX 2207
SCHENECTADY NY 12303

Or by email to: myspendingaccounts@mvphealthcare.com

Dependent Care expenses must be for the care of one or more of the following Qualifying Persons:

1. Your qualifying child who is your dependent and who will be under the age of 13 when the care is provided.
2. Your spouse who is not physically or mentally able to care for himself or herself and lives with you for more than half the year.
3. A person who is not physically or mentally able to care for himself or herself and lives with you for more than half the year.

Please see IRS publication 503 for more information.