

Flexible Spending Account with Debit Card



Enrollment or Change Request

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

Employer Name _____ Plan Year Start Date _____

CHECK ONE	<input type="checkbox"/> Regular Annual Election	<input type="checkbox"/> Mid-Year Election Effective date: _____ Date of first payroll deduction: _____								
	<input type="checkbox"/> Change in Family Status Date of event _____ Date of first payroll deduction after change: _____ <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Divorce/separation</td> <td><input type="checkbox"/> Marriage</td> <td><input type="checkbox"/> Birth or adoption of a child</td> </tr> <tr> <td><input type="checkbox"/> Death of spouse or child</td> <td><input type="checkbox"/> Spouse became unemployed</td> <td><input type="checkbox"/> Spouse ceases to be employed</td> </tr> <tr> <td><input type="checkbox"/> Change in work hours</td> <td><input type="checkbox"/> Unpaid leave of absence</td> <td><input type="checkbox"/> Other (explain): _____</td> </tr> </table>		<input type="checkbox"/> Divorce/separation	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth or adoption of a child	<input type="checkbox"/> Death of spouse or child	<input type="checkbox"/> Spouse became unemployed	<input type="checkbox"/> Spouse ceases to be employed	<input type="checkbox"/> Change in work hours	<input type="checkbox"/> Unpaid leave of absence
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EMPLOYEE INFORMATION (PLEASE PRINT)

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

Street Address _____ Social Security No. _____

City _____ State _____ Zip Code _____ Employee ID _____

Email _____ Telephone _____

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

FAMILY MEMBERS ASSOCIATED WITH THIS FLEXIBLE SPENDING ACCOUNT (FSA)

<input type="checkbox"/> Spouse	Name _____	<input type="checkbox"/> Request Debit Card for this individual
<input type="checkbox"/> Dependent	Social Security No. _____ Date of Birth _____	
<input type="checkbox"/> Dependent	Name _____ Social Security No. _____ Date of Birth _____	<input type="checkbox"/> Request Debit Card for this individual
<input type="checkbox"/> Dependent	Name _____ Social Security No. _____ Date of Birth _____	<input type="checkbox"/> Request Debit Card for this individual

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
<input type="checkbox"/> Medical Reimbursement Account <i>(Reimbursement for family health care expenses not paid from any other source)</i>	\$ _____		\$ _____
<input type="checkbox"/> Dependent Care Reimbursement Account* <i>(Reimbursement for day care expenses for eligible dependents)</i>	\$ _____		\$ _____

*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 _____

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 wish to terminate them from the plan.

Return this completed form by mail to: ATTN: MVP ANCILLARY SERVICES Or by email to: mypendingaccounts@mvphealthcare.com
MVP HEALTH CARE
PO BOX 2207
SCHENECTADY NY 12303