Your Options

There are several accounts you can participate in with Flex:

I: Healthcare Flexible Spending Account

This account reimburses you for healthcare expenses not covered by insurance. You set aside money, tax-free, through regular payroll deductions. During the year, you can be reimbursed directly from your account for those qualified healthcare services provided that are not covered by insurance. Common expenses that qualify for reimbursement are: doctor visits, deductibles, co-payments, prescriptions, mental health care, dental services and orthodontics, chiropractor services, eye exams, glasses, contacts and over-the-counter medicines.

II: Dependent Daycare Account

This account reimburses you for daycare expenses for eligible children and adults. Through regular payroll deductions, you set aside part of your income to pay for these expenses on a tax-free basis. To qualify, your dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least 8 hours a day in your household.

Qualified Expenses for reimbursement include—adult and child daycare centers, preschool and before/after school care.

Please check with your Employer HR Dept. or Consociate Customer Service at 1.866.855.8970 for additional restrictions.

PLEASE NOTE: A dependent care credit is available on your annual tax return. Whether or not to participate in the daycare portion of this plan depends on your income, filing status, number of dependents and annual daycare expenses. You will also receive your tax savings throughout the year, rather than once a year when you file your taxes. Contact your plan administrator for further information.

CONSOCIATE HEALTH

Flex Participation Form

HR/Payroll Use Only

Effective Date _____

First Contribution Date _____

# of pay periods (circle one)

12 18 24 26 52 Other ____

General Information

Plan year or plan effective date		
Employer name*	Date of Birth* (Month/Day/Year)	
Employee Name (First, Middle, Last)*	Social Security No.*	
Department	E-mail* (Please note that future correspondence will be sent electronically to the email provided.)	
Home address*		
City*	State*	Zip*
Home phone ( )	Work phone ( )	

*Required field

I authorize the employer listed above to make salary reduction contributions(s) on my behalf to the following sub account(s):

Option I: Healthcare Flexible Spending Account

◯ I elect to contribute: $ _____ per pay

$ _____ annual

If available: ◯ I elect Automatic Claim Reimbursement (Not available with Debit card). (Please check with Employer HR Dept. for availability)

◯ I elect Debit Card (Not available with Automatic Claim Reimbursement). (Please check with Employer HR Dept. for availability)

Option II: Dependent Daycare Account

◯ I elect to contribute: $ _____ per pay

$ _____ annual

Note: (Maximum amount per calendar year is the lesser of; (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3)1/2 of your total annual compensation. If you are single, the maximum amount is $5,000.)

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. A copy of the Summary Plan Description is available upon request.

Employee Signature: _____ Date: _____

WAIVER

I have reviewed the Flexible Spending Account Program offered by my employer and elect not to have eligible expenses paid with pre-tax dollars under the following accounts: 1. Healthcare Flexible Spending Account and 2. Dependent Daycare Account. I further understand that I will not have an opportunity to enroll in the Flexible Spending Account Program until the next plan year, unless I meet the qualifications as set forth by IRS guidelines.

Print Name _____ Date _____

Employee Signature _____