RESET FORM

# FLEXIBLE BENEFIT PLAN ENROLLMENT APPLICATION

Voya Benefits Company, LLC
*A member of the Voya® family of companies*
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Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by WEX Inc. For all other products, administration services provided in part by WEX Health, Inc.

## SECTION 1. EMPLOYEE INFORMATION *(Print clearly to ensure your account is set up accurately.)*

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date *(mm/dd/yyyy)* _____ Social Security Number (SSN) *(Required)* _____

Check if new address

Address _____

City _____ State _____ ZIP _____

Daytime Phone (_____)_____ Email [1] *(Required.)* _____

Employer Name _____ Division *(if applicable)* _____

## SECTION 2. FLEXIBLE BENEFIT PLAN PRE-TAX ELECTIONS

**Health Care Reimbursement Account:** Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body".

| A. Your Contribution Per Pay Period | B. Number of Pay Periods | C. Total Election (A x B = C) (Maximum Election Allowed is $2,750) | Benefit Effective Date | First Payroll Date (Required For Mid-Year Enrollments) |
|---|---|---|---|---|
| $ | | $ $ 0.00 | | |

**Dependent Care Assistance Account:** Eligible dependent day care expenses are incurred to allow you and your spouse *(if applicable)* to be gainfully employed. Remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

| A. Your Contribution Per Pay Period | B. Number of Pay Periods | C. Total Election (A x B = C) (Maximum Election Allowed is $5,000 and $2,500 if married filing separately) | Benefit Effective Date | First Payroll Date (Required For Mid-Year Enrollments) |
|---|---|---|---|---|
| $ | | $ $ 0.00 | | |

## SECTION 3. DEBIT CARD

You will automatically receive a set of two identical debit cards that you can use to access FSA funds when paying at the point of service/sale or when paying a bill. Debit cards will be mailed to your home address.

Additional and replacement cards can be ordered via your consumer portal, or by contacting Voya at 833-232-4673 or voyasupport@voya.benstrat.com. Fee may apply.

[1] *Your email address will not be shared, sold or used for purposes other than contacting you regarding your FSA.*

## SECTION 4. DIRECT DEPOSIT AUTHORIZATION

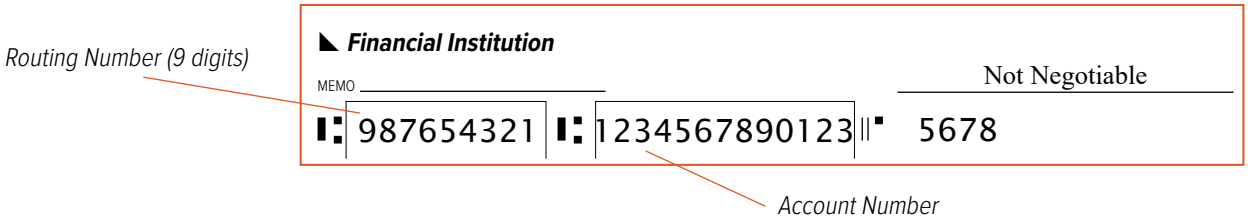
If you would like non debit card reimbursements to be direct deposited to your bank account *(rather than receiving paper checks)* fill out the information below EACH PLAN YEAR AND attach a voided check. If you do not complete this information each plan year you will be defaulted to check.

Direct Deposit Information

Bank Name _____ Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number *(9 digits)* _____ Bank Account Number _____

Sample Check




## SECTION 5. SIGNATURES

By signing below, I agree to the following terms and conditions:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts **cannot** be reimbursed from any other source, and **must** be incurred during the Plan Year unless a grace period is applicable. Any money unclaimed from my reimbursement account(s) at the end of the Plan Year, will be forfeited to my employer after a run-out period and any applicable plan provisions occur. I will not receive it back.
- For expenses reimbursed through this account I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
- The IRS requires me to keep documentation of all my expenses claimed and supply them to Voya if requested.
- I have read and understood all of the plan details outlined in my Summary Plan Description.

Employee Signature *(Required.)* _____ Date _____

Employer Acceptance *(Required.)* _____ Date _____