

ENROLLMENT / CHANGE FORM
Flexible Spending Accounts with
Beniversal™ MasterCard® Prepaid Card



plans that perform

2320 Brighton-Henrietta Townline Rd
 Rochester, NY 14623
 Phone: 1-800-473-9595

Website: www.BenefitResource.com

EMPLOYER: _____

EFFECTIVE DATE

____ / ____ / ____

____ / ____ / ____

PLEASE CHECK ONE

New Enrollment

Change* (Complete Section D)

A. EMPLOYEE INFORMATION: (Please print clearly.)

Member ID (typically your SSN): _____ Employee Status (please check one): Full-Time Part-Time

Employee Name: (Last) _____ (First) _____ (MI) _____

Home Address: (Street) _____ (Apt #) _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone #: () - _____ Hire Date: / / Birth Date: / /

E-mail Address: _____

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with Section 125 of the Internal Revenue Code.

B. BENIVERSAL CARD: (This section must be completed.) SAVE ALL RECEIPTS!

Must Check One:

Please send me a Beniversal card to use for qualified expenses. (I am not a current cardholder.) I DO NOT want a Beniversal Card.

NOTE: You must provide email address above to receive a card.

I am a current Beniversal Cardholder and wish to keep my current card. Cancel my current Beniversal Card.

C. FLEXIBLE SPENDING ACCOUNTS: (Please enter your FSA elections.)

(Refer to your Plan Highlights for monthly election maximums)

Dependent Care Flexible Spending Account (DCA)

Medical Flexible Spending Account (MED)

Per Pay Deduction

\$ _____

\$ _____

Plan Year Election

\$ _____

\$ _____

D. EMPLOYER SECTION: (This section must be completed or the form will be returned.)

• Deduction cycle: weekly bi-weekly monthly semi-monthly other _____

• Pay Date of first deduction: ____ / ____ / ____ • # of pay dates on which FSA deductions will be taken during this Plan Year: ____

• Health Plan Name and Sub Plan Name: _____

(e.g. Preferred Care, Tri Vantage, Family Focus) Note: If Employee is not insured through your Plan(s), enter **No Coverage** on the line.

E. *MIDYEAR CHANGE INFORMATION: (Please check applicable event.)

NOTE: • An election can only be changed if the change in status affects eligibility for that coverage.

• Any change in election must be consistent with the change in status and the change in eligibility.

Participant's termination of employment. Last date of employment: ____ / ____ / ____.

Participant's commencement of employment.

Change in employment status of spouse or dependent (including termination or commencement of employment).

Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).

Change in number of tax dependents (including birth, adoption, placement for adoption, death).

Change in work schedule (reduction or increase in hours by employee, spouse or dependent, including a switch between full-time and part-time, a strike or lockout, and commencement of or return from an unpaid leave of absence).

Change in residence or worksite (of employee, spouse, or dependent).

Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).

Change in dependent care cost or provider (for Dependent Care FSA elections only).

Other _____

• I have received and read the printed material which explains my Plan and my options under it. I understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current Plan Year. Any choices above may be modified only as defined in the Plan. I also understand that any reimbursed expenses under this Plan are eligible expenses as governed by IRS regulations, are for myself and a qualifying individual, and are not reimbursable from any other source. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that any unused amounts in either Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.

• If elected, I authorize the issuance of a Beniversal™ MasterCard® by a bank chosen by Benefit Resource and understand that Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account (such as social security number, address and date of birth). I agree to use this card only for eligible Plan expenses for myself or eligible dependents and to be bound by all provisions of the Beniversal Cardholder Agreement and My Use of Card Promises sent to me as a result of this application. Furthermore, I understand that if my Beniversal card is used for expenses other than those eligible for reimbursement under the Plan or if I violate the terms of the Beniversal Cardholder Agreement, I may lose Beniversal card privileges and will reimburse the Plan for the expenses. I also authorize my Employer to deduct any non-approved expense directly from my paycheck on an after-tax basis.

• Since the IRS requires substantiation for certain purchases made with the Beniversal card, I agree to acquire and retain sufficient documentation for any expense paid with the card.

Signature: _____ Date: ____ / ____ / ____

Please return completed form to your employer.