Flexible Spending Account (FSA) Enrollment Form

Employee Information *(Please print clearly)*

Social Security No.____________________ First Name, Middle Initial ____________________

Last name ____________________ Date of Birth (mm/dd/yyyy) ____________________

Date of Hire (mm/dd/yyyy)__________ Area Code ________ Phone number ____________________

Home Address____________________

City ____________________ State ________ Zip Code ____________________

email ____________________

Employer to complete this section

Employer Name ____________________ Dept/Division/Client ____________________

Payroll Frequency __________ No. of Payroll Deductions __________ Hours per Week __________

Employee Plan Effective Date (mm/dd/yyyy)__________ Date of 1st Payroll Deduction __________

Deduction Code ____________________ ❑ Short Plan Year ❑ 12-Month Plan Year

Employee Elections *(Employee to complete the information below)*

❑ **Yes, I want to enroll**. My elections are below.

❑ **No, I do not want to enroll**. If a change in status occurs, I may have the right to enroll in the plan at that time (if plan allows).

A. **Group Medical Premiums.** If you participate in your employer's insurance plan(s), your premiums will automatically be deducted on a tax free basis under this plan unless you notify your Human Resources or Personnel Department.

	Annual Election	Divided by (/) Number of Payrolls	Equals (=) Amount Per Pay Check	Employer Contribution *(if applicable)*	
				Per Month	Per Year
B. Health FSA	$	/	$	$	$
C. Dependent Care FSA	$	/	$	$	$
D. Premium Reimbursement Account (PRA)	$	/	$	$	$
E. Limited Purpose FSA	$	/	$	$	$
Totals	$	/	$	$	$

❑ My employer offers the claims auto download through my medical carrier. I would like to take advantage of this service.

Direct Deposit Information *(Complete this section if you are a new eflex customer or if your bank account information has changed in the past year. You don't need to complete this section if you had direct deposit in the last plan year and your bank account information hasn't changed.)* **IMPORTANT: Please provide a voided check (not a deposit slip) for each account listed below. We can't process without a voided check**.

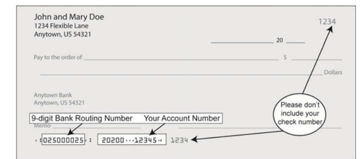
Bank Name ____________________ Bank Address____________________

City ____________________ State ________ ZIP Code __________

Name on the Account ____________________ Routing and Transit Number____________________

Account Number____________________ Account Type ____________________

With my signature below, I authorize reimbursements from my eflex plan to be sent to the financial institution named above to be deposited in the designated account. In the event funds are deposited erroneously into my account, I authorize eflex to debit my account(s) not to exceed the original amount of the credit. I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.



In setting up my eflex plan, I understand and agree that the IRS regulations state four conditions: 1) Any expenses I/we incur must be within the plan year; 2) Any expenses I/we incur must not be covered by any other source, such as insurance; 3) I/we must provide proper documentation to receive payment; 4) I/we cannot change or revoke elections during the plan year unless there is a specific change in status and my employer allows such changes. Please see the Summary Plan Description for details.

Signature ____________________ Date__________

Fax, email, or mail this completed form with a voided check to your HR/Personnel Department.

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e: customercare@eflexgroup.com | w: eflexgroup.com

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Use or Disclosure Authorization

Complete this form to allow spouse, family members and/or agents to discuss your eflex account, claims, and other plan-related details with us.

By completing this Use or Disclosure Authorization, I hereby authorize eflex/eCOBRA the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to eflexgroup.com (eflex/eCOBRA).

I authorize the following person(s)/organization(s) to receive and/or discuss health information for me and my dependents.

Last name, First name	Relationship (e.g., spouse, agent, etc.)	Company (if applicable)	Disclose all health information? (Y/N) *If No, please provide specific description of information to be used or disclosed*

I understand the specific purpose of the disclosure may be made at the request of the authorized individual: ❑ Yes ❑ No

This authorization will expire upon termination of coverage. However, I may revoke authorization at any time by submitting written revocation to eflex/eCOBRA.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying eflex/eCOBRA, in writing, but the revocation will not have any effect on any actions that may have occurred before receiving the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- Information used or disclosed pursuant to this authorization may be re-disclosed by persons/organizations I have authorized to receive information. I have the right to seek assurances from the above-named persons/organizations that they will not re-disclose information to any other party without my further authorization.

Your Full Name (print) ______________________________ Your SSN ______________________________

Your Date of Birth ______________________________ Employer Name ______________________________

Your Signature ____ Date____________________

Please keep a copy for your records. Mail, email, or fax completed authorization to:
eflex Customer Care, 2740 Ski Lane, Madison, WI 53713
f: 877-231-1287 | e: customercare@eflexgroup.com

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