# FLEXIBLE SPENDING ENROLLMENT FORM

| APPLICANT INFORMATION | | | | | |
|---|---|---|---|---|---|
| EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) | SEX | DATE OF BIRTH | SOCIAL SECURITY # | | |
| STREET ADDRESS | CITY | | STATE | ZIP CODE | EFF DATE |
| HOME PHONE | WORK PHONE | | EMAIL ADDRESS | | |
| TYPE<br>☐ New Enrollment ☐ Change | | | PEBP EMPLOYEE ID# | | |

If Change, please mark one of the following:

☐ Marriage ☐ Divorce ☐ Birth / Adoption ☐ Change of Spouse's Employment ☐ Death of Spouse or Child ☐ Change in Eligibility Status

☐ Other _____

**PLEASE INDICATE YOUR DESIRED BENEFIT OPTIONS BY CHECKING THE APPROPRIATE BOX(ES)**

## ☐ HEALTH CARE FLEXIBLE SPENDING ACCOUNT

My taxable compensation is to be reduced for qualifying health care expenses in the amount of:

$_____ = _____ × $_____
Annual Election # of Pay Periods Per Payroll Deduction

Note: The annual election must equal the per payroll deduction multiplied by the number of pay periods remaining for the fiscal year

Note:
Maximum $2750 per year

## ☐ LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

My taxable compensation is to be reduced for qualifying health care expenses in the amount of:

$_____ = _____ × $_____
Annual Election # of Pay Periods Per Payroll Deduction

Note: The annual election must equal the per payroll deduction multiplied by the number of pay periods remaining for the fiscal year

Note:
Maximum $2750 per year

For use in conjunction with the HSA. May only be used for Vision & Dental expenses.

## ☐ DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

My taxable compensations is to be reduced for qualifying dependent care expenses in the amount of:

$_____ = _____ × $_____
Annual Election # of Pay Periods Per Payroll Deduction

Note: The annual election must equal the per payroll deduction multiplied by the number of pay periods remaining for the fiscal year

Note:
Maximum $5000 per year for married couples filing a joint tax return, or single individual. $2500 if married and filing a separate tax return.

***By signing my name below, I agree or understand that:***

This election is irrevocable during the plan year. The only exception to this is if I have a qualified change in family status. Reduced amounts of taxable compensation not used to pay eligible benefits during the plan year will be forfeited. My employer may change or suspend the reduction of compensation if the Internal Revenue Service, through legislation or restrictive regulation, limits or prohibits salary reduction as currently permitted under Section 125 of the Internal Revenue Code. Compensation contributed into one of the two Flexible Spending Accounts cannot be transferred and used for expenses in the other Flexible Spending Account. Associates with multiple group health and/or dental coverage on themselves or any of their dependents cannot have claims automatically reimbursed through flex. I agree to execute this salary reduction agreement in accordance with the master plan document. I advise HealthSCOPE Benefits, Inc. that the claims I submit to HealthSCOPE Benefits, Inc. as the third party administrator for my employer's group health and flexible spending account plans, have not been reimbursed and are not reimbursable under any other health plan coverage. I will notify HealthSCOPE Benefits, Inc. immediately if I become aware that any such claims are reimbursed or become reimbursable under any other health plan coverage. My Social Security benefits may be slightly reduced as a result of my election.

_____ _____
EMPLOYEE SIGNATURE DATE

**PLEASE SEND COMPLETED FORM TO:**

**MAIL:** **HealthSCOPE Benefits**
**P.O. Box 3627**
**Little Rock, AR 72203**

**E-MAIL:** **PEBPFSA@HealthSCOPEBenefits.com**

**FAX:** **1-877-240-0135**