Benefit Resource, Inc.
plans that perform

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

ENROLLMENT FORM
FLEXIBLE SPENDING ACCOUNTS

(PLEASE PRINT CLEARLY)

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID:

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

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time

Email Address: _____
(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

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. FLEXIBLE SPENDING ACCOUNTS (FSAs) ***Please enter your FSA election(s) below.***

(Refer to your Plan Highlights for election maximums)	**Per Pay Deduction**	**Plan Year Election**
☐ Medical FSA *Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.*	$ _____	$ _____
☐ Dependent Care FSA	$ _____	$ _____

C. EMPLOYEE CERTIFICATION ***Return signed form to your employer.***

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also 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. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account will be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid MasterCard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card by a bank chosen by Benefit Resource. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the cardholder agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the agreement, my account may be suspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature: _____ Date: _____ / _____ / _____

D. PAYROLL DEDUCTION INFORMATION ***Employer must complete this section for employee to be enrolled.***

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other _____
- **Pay Date of first FSA deduction(s):** _ _/_ _/_____
- **Number of pay dates on which FSA deduction(s) will be taken during this plan year:**
- **Health Insurance Coverage Code:** ***This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.***

The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT REIMBURSEMENT

(PLEASE PRINT CLEARLY)

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245 Kenneth Drive
Rochester NY 14623-4277

Phone: (800) 473-9595

Fax: (585) 697-0331
or
(585) 424-7273

www.BenefitResource.com

Please Check One: ☐ Set up new Direct Deposit ☐ Change Direct Deposit Account ☐ Cancel Direct Deposit

EMPLOYEE INFORMATION

Employer Name:

Employee Member ID:

Last Name: First Name: MI:

Address:

City: State: Zip:

Phone Number:

BANK ACCOUNT INFORMATION

Account Type *(please check one)*: ☐ Checking Account ☐ Savings Account

Name of Bank: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

An empty block should indicate spaces between words.

Bank Routing #: ☐☐☐☐☐☐☐☐☐

Account #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(Please allow 14 days after receipt by Benefit Resource, Inc. for bank pre-notification to be completed.)

AUTHORIZATION AGREEMENT

I hereby authorize Benefit Resource, Inc. to initiate credit entries to the bank account indicated above and, if necessary, to initiate debit entries and adjustment for any credit entries made in error to my account. This authorization is to remain in full force and effect until Benefit Resource has received written notice from me of its termination and has had a reasonable opportunity to act on it. I understand that this authorization cannot be processed unless it is completed in full and returned to Benefit Resource. By authorizing any direct deposits, I certify that the reimbursed expenses qualify for reimbursement under IRS regulations, are for a qualifying individual, and will not be reimbursed from any other source.

Signature: ____ Date: ______/________/________

Please return completed form to Benefit Resource, Inc. Retain a copy for your files.

Internal Use Only: Initial and Date FSA/HRA ______________ CBP ______________