benefit strategies LLC

Carnegie Institution of Washington

LIMITED PURPOSE FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

CARNEGIE SCIENCE

A. Employee Information — *Please Print Clearly!* — Instructions on Back

Name: ______________________ Social Security Number (Required): ______________

Home Address: ______________________ Date of Hire: ______________

Check if New: ☐

City: __________ State: __________ Zip Code: __________ Day Phone: __________

E-mail Address (Required): ______________________ Date of Birth: __________

B. Flexible Benefit Plan Pre-tax Elections

1. Limited Purpose Health Care Account

Eligible expenses include professional dental and vision 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".

$	X		=	$	Election Allowed $2,750 Maximum
Your Contribution Per Pay Period		# of Pay Periods		Total Election	

C. *FlexExpress©* Debit Card

The FlexExpress Cards© are optional. If you and/or your dependents have debit cards, they will automatically be reactivated unless you indicate below that you do not want cards. Otherwise, please indicate your selection below. Annual Fees: Paid by Employee, Cost $5.00 per set.

Check One:	**** If you and/or your dependents have debit cards, they will be automatically reactivated for your renewal. Otherwise, please select from below:***		NO action required.
	☐	I am a new participant to this plan and would like a NEW set of debit cards.	This is for brand new participants only; You will receive 2 cards. If you already have cards, selecting this option will automatically inactivate your existing cards.
	☐	I have cards that were lost, stolen or damaged and would like a replacement set of cards.	Selecting this option will inactivate and replace all of your existing cards. Replacement fee is $15.00 per set.
	☐	I do NOT want FlexExpress Cards.	Your default reimbursement method will be check unless the direct deposit information below is completed.

Additional Card Information: Please indicate the number of *additional* cards you would like to request below (If you request a card for yourself you will get 2 to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.) Additional sets are $5.00 per set.

Number of Additional Sets Requested:

D. 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.

Bank Name: (See #1 on sample)

☐ Checking Account

☐ Savings Account

Routing Number – 9 digits (See #2 on sample):

Account Number (See #3 on sample): ______________

SAMPLE

Account Holder's Name Address, Etc. — Check Number — Transit Code ex: 23-94/1002 — DOLLARS — 1 Bank Information Name of Bank Address, Phone — 2 9 Digit Routing Number — 3 Checking Account Number

E. 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.
- I understand that my employer may allow me to carryover unused funds up to plan limits at the end of the plan year for deposit into the next following plan year for future use. Any money unclaimed from my Health Care Reimbursement Account(s) at the end of the Plan Year in excess of the carryover limits will be forfeited to my employer after a run-out period. 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 Benefit Strategies 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):		Effective Date:	
*If this is a mid-year enrollment, please list the first payroll date for deductions.		First Payroll Date:	