SWA

STATE OF WASHINGTON

FLEXIBLE SPENDING ARRANGEMENT (FSA) & DEPENDENT CARE ASSISTANCE PROGRAM (DCAP) ENROLLMENT FORM

FOR PLAN YEAR JANUARY 1, 2015 THROUGH DECEMBER 31, 2015

Instructions

1. Complete Section I — Employee Information.
2. Complete Section II — Elections. Check **YES** for benefits you want to enroll in and give the per plan year and per paycheck deduction amounts. If you are not sure how many paychecks you will receive, contact your personnel, payroll, or benefits office.
3. Complete Section III — Signature. Return form to the appropriate contact shown on the bottom of this page by specified deadline.

Section I – Employee Information

Name (Last, First, MI):			SSN (Employee I.D. if Higher-Education):	
Street Address:	City:		State:	ZIP Code:
Daytime Phone:	Home Phone:	Agency or Higher-Education Institution Name:		
Date of Birth:	Email Address:	Enrollment Status: ☐ New Hire ☐ Career Seasonal/Contract Employee		

Section II – Elections

Benefit		2015 Election Amount (State employees, Higher-Education, Community and Technical Colleges)	(To be used by state employees only) # Paychecks	(To be used by state employees only) Paycheck Deduction
Health Care FSA Minimum of $240, Maximum of $2,500	❑ Yes ❑ No	$_____ per plan year	_____ # of paychecks	$_____ per paycheck
Flexi-Card FSA Debit Card A debit card that pays for your expenses from the Health Care FSA	❑ Yes ❑ No	**You must provide a valid email address to receive the Flexi-Card Debit Card**. There is no cost to receive the first two debit cards and you are not required to use them. You must elect the card each year you want to use the card and your current card will be reloaded.		
	❑ YES, send a card for my eligible spouse or dependent.	❑ Spouse ❑ Dependent _____ Last Name, First Name		
Dependent Care Assistance Program Maximum of $5,000 per plan year ($2,500 if married and filing separately)	❑ Yes ❑ No	$_____ per plan year	_____ # of paychecks	$_____ per paycheck
Direct Deposit Reimbursements are electronically deposited into your bank account. If you leave this section blank we will mail your reimbursements to you.	❑ Yes ❑ No	Name of bank: ❑ Checking ❑ Savings	Routing #_____ Account #_____	

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new elections are consistent with federal regulations and PEBB rules. I understand that I will only receive reimbursements for qualifying medical care or day care expenses. By signing below I acknowledge that I understand the benefits, I have read both sides of this enrollment form, and agree to the terms of use. I authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) and for the plan year indicated above.

Section III – Signature

Employee Signature X	Date

Employees: Return this form to your employer's personnel, payroll, or benefits office.

Employer Signature X	Date

Employer: After reviewing the form, fax to 425-233-6366, email to election@flex-plan.com, or mail to Flex-Plan Services, P.O. Box 53250, Bellevue, WA 98015. For assistance call 1-800-669-3539.

Please see the next page for important information about the above benefits.

Additional Information

- **Health Care Flexible Spending Arrangement (FSA):**
  - Reimbursement will only be approved for qualifying medical care expenses as allowed in Internal Revenue Code. It is your responsibility to check the eligibility of an expense.
- **Dependent Care Assistance Program (DCAP):**
  - Reimbursement will be available only for qualifying day care expenses as allowed in the Internal Revenue Code.
  - If the plan year is less than 12 months, the plan limit may be prorated to less than the $5,000 calendar year limit.
- **Use It or Lose It Rule**
  - You must claim all your 2015 elected funds by March 31, 2016. Money left in your account(s) after March 31, 2016 will be forfeited to the administrator, the Health Care Authority, and will not be refunded to you.

Grace Period and the Use It or Lose It Rule

- There is a grace period for the FSA to incur FSA claims against the previous plan year. All services must be rendered by March 15, 2016.
- All DCAP services must be incurred by December 31, 2015.
- All claims (FSA and DCAP) must be submitted to Flex-Plan Services by March 31, 2016.
- Any 2015 amount not claimed by March 31, 2016 will be forfeited to the Health Care Authority. Once the money is forfeited, you will not be able to claim it.

Lost Checks and Reissues

- Lost or stale dated FSA checks can be reissued 10 business days after the original check date. Flex-Plan Services will charge a $25 check reissue fee. A check reissue requires at least one business day to process.
- Any fees associated with presenting a canceled check will be deducted from your account as well as the face value of the check.

Direct Deposit

- Deposits by electronic funds transfer may take up to two business days to appear in the designated account.
- Flex-Plan Services will deduct a $10 fee from your FSA balance for returned items due to incorrect banking information.

Deductions

- FSA and/or DCAP deductions will be taken from your paycheck evenly throughout the plan year.
- Deductions will start no earlier than the first paycheck of the month after this form is submitted and approved by Flex-Plan Services.

Change in Status

- The amount you set as your annual election is considered irrevocable for the entire plan year unless a qualifying event occurs to allow a special open enrollment change in status. See the enrollment guide for a list of qualifying events.
- If you have a change in status and want to change your election, your change must be because of and consistent with the change in status. The change also must be acceptable under IRS regulations.

Ineligible Flexi-Card Expenses

- Flex-Plan Services may use the following methods for correcting the reimbursement of an ineligible Flexi-Card charge. A participant must: a) repay the FSA balance for the amount of the ineligible expense to Flex-Plan Services, or b) request the substitution or offset of future claims to repay the FSA balance.
- If you use the card for an ineligible expense the card will be suspended to prevent further use. Flex-Plan Services will reactivate the card once you reimburse the account for the amount of the ineligible expense. You may still submit claims via fax or mail. Upon request, we will substitute or offset those future claims against the amount of the ineligible expense until the amount of the ineligible expense is repaid.

Lost or Stolen Flexi-Card

- Flex-Plan Services will charge $5 from your FSA balance to reissue a lost, stolen, or misplaced Flexi-Card.
- Your first two debit cards will be issued at no cost. Each additional debit card ordered will incur a $5 fee deducted from your FSA balance.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Flex-Plan, agents, and subcontractors about your account.
- If you no longer wish to receive information electronically, you may withdraw consent at anytime at no cost. To withdraw consent, please contact Flex-Plan Services at 1-800-669-3539.
- You have the right to receive a paper version of an electronic document at no cost.
- To access documents you must have Adobe Reader. Flex-Plan Services will include a link to download this free software with electronic documents sent to you.

How to contact Flex-Plan Services

Business hours: Monday – Friday, 6 a.m. – 6 p.m., PST

Phone: 1-800-669-3539 or 425-452-3500
Email: customerservice@flex-plan.com
Fax: 425-451-7002 or toll-free FAX 1-866-535-9227
Mail: Flex-Plan Services, PO Box 53250, Bellevue, WA 98015