

FY2019 Open Enrollment TOWN OF NEEDHAM, MA

FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

DEADLINE: May 11, 2018 at Noon - Enrollment Form to your HR Department

Name: Social Security Number (Required):	A. Employee Information Please Print Clearly.										
City: State: Zip Code: Day Phone:	Name:							Social Security Number (Required):			
City: State: Zip Code: Day Phone: E-mail Address: Date of Birth: B. Floxible Bonefit Plan Pre-tox Elections Health Care Relimbursement Account: Eighbe health openess include professoral nectical expenses incurred by my dependents or myelf 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." S. X.			•						-	• /	
E-mail Address; Date of Birth: B. Floxible Bonefit Plan Pro-tax Elections 1. Health Care Reimbursement Account Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Ran Year for "the diagnosis, cure mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body". S. X. X. X. X. Your Contribution Per Pay Period Pour Express Debit Card Pour Express Debit Card Pour Pay Period Pour Contribution Per Pay Period Pour Express Debit Card Pour Pay Period Pour Express Debit Card Pour Pay Period Pour Pay	Check	if New: ∟	J _								
B. Flexible Benefit Plan Pre-tax Elections 1. Health Care Reimbursement Account Eligible health expenses include professional medical expenses incurred by my dependents or mynet during the Plan Year for "the diagnosts, cure mitigation, treatment or previous of disease, or for the purpose of affecting any structure or function of the body." S. X.	City: State:				Zip Code:			Day Phone:			
Health Care Reimbursement Account Eligible health expenses include professional medical expenses incurred by my dependents or prevention of disease, or for the purpose of affecting my structure or function of the body. Some contribution Per Pay Period	E-ma	ail Addr	ess:	-						Date of Birth:	
Employed Person for "the disagooss, cure mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of function of the body".	B. Flexible Benefit Plan Pre-tax Elections										
Pependent Care Assistance Account Eighle dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the ISs will require you to disclose the Tox ID or social Security Number of your day care your flower between the Tox ID or social Security Number of your day care your dependents when you file your income taxes. S	1.										ng
Total Election Total Election	_	\$			x		= \$			_	
employed. Please remember that the IIS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes. S				•		•				·	
Total Election Total Election											
Total Election C. FloxExpress® Debit Gard The FlexExpress Cardos are optional. If you and/or your dependents have debit cards, they will automatically be reactivated unless you undicate below that you don't want cards. Otherwise, palease select from below: Check One:	\$				х		= \$			_	
Additional Card Information: Please indicate the number of additional cards you would like a new participants only; You will receive 2 cards. If you additional Sets Requested: Additional Sets Requested: Cample: 2, 4, 6, 8, etc. Additional sets are 30 per set.											
**If you and/or your dependents have debit cards, they will be automatically reactivated for your renewal. Otherwise, please select from below: Am a new participant to this plan and would like a NEW set of debit cards.											
Select from below: Check One:	you me	areate beto	* If you and/or your dependents have debit cards, the				s, they	will be	e		
Check One: I have cards that were lost, stolen or damaged and would like a replacement set of cards. I have cards that were lost, stolen or damaged and would like a replacement set of cards. I have cards that were lost, stolen or damaged and would like a replacement set of cards. I do NOT want FlexExpress Cards. 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 50 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 SaMPLE										·	_ If
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 cards are \$0 per set.	Chec	eck One:						NEW set of	you already have cards, selecting this option will automatically		
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 \$0 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 SAMPLE Savings Account SAMPLE Count Number (See #3 on sample): 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses paid or 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. Payroll Frequency: Semi-Monthly (24) Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Non-Rep (Town) TIWA Police Fire BCTIA NIPEA Non-Rep (School) NEA Employer Acceptance (required):	Onco							would like a			
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) Routing Number - 9 digits (See #2 on sample): Account Number (See #3 on sample): Account Number (See #3 on sample): I leands thorousion Name that is 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses paid or 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): Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Date: Employer Acceptance (required): Benefit Effective Date:				I do NOT want FlexExpress Cards.							
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) Savings Account											
Checking Account SawPLE Savings Account Routing Number - 9 digits (See #2 on sample): Account Number (See #3 on sample): Account Number (See #3 on sample): 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses paid or 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. Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Name of Back Address, Panne Path Address, Etc. Savings Account Account Number (See #3 on sample): Account Number (See #3											
Checking Account SawPLE Savings Account Routing Number - 9 digits (See #2 on sample): Account Number (See #3 on sample): Account Number (See #3 on sample): 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses paid or 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. Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Name of Back Address, Panne Path Address, Etc. Savings Account Account Number (See #3 on sample): Account Number (See #3	D. D	Direct D	Deposi	it Authorizatio	on If you wou	ld like non debit (card rei	mbursements to	be direct de	eposited to your bank account (rather than receiving paper	
Savings Account Savings Ac	checks	ne inform	ation below EACH F	PLAN YEAR AN	ID attach a voided	ach a voided check. If you do not co			formation each plan year you will be defaulted to check.		
Routing Number - 9 digits (See #2 on sample): Account Number (See #3 on sample): Bank Information Number Checking Account Number Checking Account Number Checking Account Number Signatures Signature Signatures Signature Signat										Account Holder's Name Check 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. • For expenses paid or 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: Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Benefit Effective Date: Benefit Effective Date:	(See #1 on sumple)						□ Savings Acc			Total Constitution B	
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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. • For expenses paid or 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: Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Benefit Effective Date:	Routing Number - 9 digits (See #2 on sample): Account Num						Numb	mber (See #3 on sample):		1 Bank Information Name of Bank	
 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses paid or 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: Date: Union Representation: Non-Rep (Town) ITWA Police Fire BCTIA NIPEA Non-Rep (School) NEA Employer Acceptance (required): Benefit Effective Date: 										PM 2 3	
Employee Signature (required): Date: Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Non-Rep (Town) ITWA Police Fire BCTIA NIPEA Non-Rep (School) NIPEA Non-Rep (School) NEA Employer Acceptance (required): Benefit Effective Date:	 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 Flexible Spending Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my Flexible spending account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses paid or reimbursed through this account I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits. 										
Payroll Frequency: Semi-Monthly (24) Weekly (52) Weekly (38) Weekly (42) Union Representation: Non-Rep (Town) ITWA Police Fire BCTIA NIPEA Non-Rep (School) NEA Employer Acceptance (required): Benefit Effective Date:					e plan details outlined in my Summary Plan Description.			Description.		Date	
Union Representation: ONon-Rep (Town) OITWA OPOlice OFire OBCTIA ONOn-Rep (School) ONEA Employer Acceptance (required): Benefit Effective Date:	. , ,				Semi-Monthly	(24) OV	Veekly ((52) □Weekly (38)			
				· · ·	2 ()						
*If this is a mid-year enrollment, please list the first payroll date for deductions. First Payroll Date:	Empl	oyer Ac	ceptan	Ce (required):						Benefit Effective Date:	
	*If th	is is a m	nid-yea	r enrollment, p	, please list the first payroll date for deducti				ions.	First Payroll Date:	