Flexible Spending Account Election of Benefits Form

Please complete this form and make a copy for your files. Return the completed form to your employer.

Terms not specifically defined in this Election of Benefits Form shall have the same meaning as those definitions set forth in the Flexible Spending Benefits Plan (the "Plan") Document.

Employer Information

Employer Name _____ CDPHP Group Number _____

Member Information

Name _____

Social Security Number _____ Date of Birth _____

Street Address _____

City _____ State _____ ZIP _____

Email Address _____

Are you enrolling in a CDPHP medical plan? ◯ Yes ◯ No

Election of FSA Benefit Options and Amount(s)

◯ I would like to participate in the Health Flexible Spending Account offered by my employer and administered by CDPHN. I pledge a total of $_____ for the coming Plan Year.

◯ I am not interested in participating in the Health Flexible Spending Account for the coming Plan Year.

◯ I am eligible to make a change and would like to make a change in the Health Flexible Spending Account offered by my employer and administered by CDPHN. I pledge a total of $_____ for the remainder of the Plan Year.

◯ I would like to participate in the Dependent Care Flexible Spending Account offered by my employer and administered by CDPHN. I pledge a total of $_____ for the coming Plan Year.

◯ I am not interested in participating in the Dependent Care Flexible Spending Account for the coming Plan Year.

◯ I am eligible to make a change and would like to make a change in the Dependent Care Flexible Spending Account offered by my employer and administered by CDPHN. I pledge a total of $_____ for the remainder of the Plan Year.

Employee Certification—Please Read and Sign

I request to participate in the Benefit Options as indicated and hereby authorize my employer to make pre-tax deductions from my compensation in the amount(s) indicated above. I understand that my elections are binding upon me for the entire Plan Year and cannot be revoked, modified, or amended except due to very limited changes in family or other status as described in the Plan Document. I further certify that any dependents for whom I will be claiming dependent care or health care expenses will meet the definition of dependent as described in applicable plan documents. I understand that future Social Security benefits may be affected should I elect pre-tax salary deductions under this Plan. My signature also confirms the additional terms and conditions outlined on the back of this form.

_____ _____

Employee Signature Date

For Employer Use—Please complete before forwarding to CDPHP

Coverage Effective Date: _____ First Payroll Deduction Date: _____ Group Administrator Initial: _____

Other Notes: _____

_____

Additional Terms and Conditions

Acknowledgment of HIPAA Notice

I acknowledge that I have been provided with the Notice of Privacy Practices as a requirement of the Health Insurance Portability and Accountability Act (HIPAA), which describes how Capital District Physicians' Healthcare Network, Inc. (CDPHN) may use or disclose my protected health information, with whom that information may be shared, and the safeguards that CDPHN has put into place to protect this information. I understand that having me initial this acknowledgment is CDPHN's intent to make me aware of the possible uses and disclosures of my protected health information and my privacy rights.

Email Consent

I consent to receive electronic communications at the above specified email address, for any and all matters permitted by law regarding the Reimbursement Plan which is sent by, or on behalf of, the Plan or my employer. I certify that I have access to the above email address and am able to receive electronic messages with attachments at that email address. Should I subsequently provide CDPHN with a different email address to use for these communications, this consent shall apply to that email address also. I understand that I may request a paper copy of any correspondence provided electronically at no charge by contacting CDPHN in writing. Neither the Plan, employer, nor any agent of the Plan or employer, shall be held liable for my not having received any communication by virtue of my inability to receive the communication at the email address I have provided. Any electronic communication sent shall be deemed to have been received by me. I may revoke this consent at any time by notifying CDPHN in writing. If I should no longer have access to the email address last provided to CDPHN, I shall immediately provide a new email address or revoke this consent.

Debit Card

I certify that I will only use the Plan debit card to purchase eligible health care and/or dependent care products and services, as defined by the Plan. I certify that I will not seek reimbursement from any other source for the expenses paid for with the Plan debit card. I agree to be bound by the terms and conditions of the cardholder agreement, which is distributed with the Plan debit card. I agree to maintain records to substantiate payment of eligible expenses under the Plan and will submit such records to CDPHN upon request by CDPHN or by my employer. If I receive reimbursement erroneously, or do not provide timely substantiation when requested, I agree to repay the Plan, and have my debit card deactivated until such repayment is made. I agree to allow my employer to deduct ineligible debit card expenses/purchases from my wages, in the event that I do not provide timely substantiation of my transactions to CDPHN, or otherwise utilize this debit card in a non-compliant manner.

Notification of Mailing Address Change or Change to Other Personal Information

I agree to notify my employer and CDPHN of any changes to my personal information that may affect the administration of my Benefit Options. This includes but is not limited to: changes in my mailing address; change of first or last name; change in email address (if provided); change of election amount (in the event of a qualifying event); change of direct deposit banking information (if provided). I understand that neither my employer nor CDPHN will be held liable for any delays, problems, or failures in the administration of my Benefit Options or in the processing of claims I submit for reimbursement due to my failure to provide this information in an accurate and timely manner.

Responsibility for Fees Associated With Reissuing Reimbursement Checks

I agree to be responsible for paying any fees associated with having CDPHN reissue reimbursement checks to me, in the event that initial payments issued to me are lost, stolen, misplaced, or otherwise not received by me in a timely manner. I agree to notify CDPHN in writing, in the event that I wish a reimbursement check to be reissued.

Capital District Physicians' Healthcare Network, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206-1057
(518) 641-3770 or 1-877-793-3960