# Election of Benefit Options Form

Flexible Spending Account (FSA) 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 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 _____

E-Mail Address _____

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

## Election of FSA Benefit Options and Amount(s)

*(Choose 1 or 2; choose 1A or 1B if selecting 1)*

◯ **1. YES,** I would like to participate in the following **Health FSA** offered by my employer and administered by CDPHN. I pledge a total of $_____ for the coming Plan Year (or remainder of the Plan Year, if election is due to a Qualifying Event).

- ◯ **1A. General Purpose Health Care** Expense Account [reimburses all eligible medical, dental and vision expenses permitted under the tax code for the employee, spouse, and eligible dependents; makes employee and covered dependents ineligible to make Health Saving Account (HSA) contributions]
  - ◯ I want to waive the ability to reimburse expenses for the following dependents, so they may contribute to an HSA: _____
- ◯ **1B. Limited Purpose Health Care** Expense Account [for employees enrolled in high deductible health plan coverage and making contributions to a HSA; reimburses dental and vision expenses only]

◯ **2. NO,** I am not interested in participating in the Health FSA for the coming Plan Year (or remainder of the Plan Year, if election is due to a Qualifying Event).

## Election of Dependent Care FSA Benefit Options and Amount(s)

*(Choose 1 or 2)*

◯ **1. YES,** I would like to participate in the **Dependent Care FSA*** offered by my employer and administered by CDPHN. I pledge a total of $_____ for the coming Plan Year (or remainder of the Plan Year, if election is due to a Qualifying Event).

◯ **2. NO,** I am not interested in participating in the Dependent Care FSA for the coming Plan Year (or remainder of the Plan Year, if election is due to a Qualifying Event).

**You can only contribute to the Dependent Care FSA if you incur expenses for the care of your eligible dependents so that both you and your spouse (if you have one) can work. If your spouse does not have income from employment, or does not meet other criteria listed in the Summary Plan Description, then you are not eligible for the Dependent Care FSA. If you are married but your Federal tax filing status is Married Filing Separately, then your maximum annual contribution is $2,500; for other tax filing statuses the maximum is $5,000. However, if your spouse's income from employment totals less than the dollar maximums above, then your maximum contribution is limited to the amount of your spouse's earned income. You cannot participate if you are divorced or a single parent and the child's other parent is the primary custodian.*

## Qualifying Events

If you are making a mid-year election change due to a Qualifying Event, indicate the event and its effective date below. Please note that not all Qualifying Events apply to FSAs. Your election change needs to be consistent with the nature of the Qualifying Event. Your election change will be effective prospectively, only after the completed form is received, and will not be retroactive to the date of the Qualifying Event.

All FSA Types:

◯ Change in marital status (marriage, divorce, annulment, death)

◯ Change in number of dependents (birth, adoption, death, dependent gains or loses eligibility)

◯ Employee or spouse gains or loses eligibility for FSA due to change in employment status

◯ Start or stop FMLA or USERRA leave of absence

Health FSA Only:

◯ Court order requires child's enrollment in health FSA or former spouse's health FSA

◯ Employee, spouse or dependent gains or loses eligibility for Medicare or Medicaid

Dependent Care FSA Only:

◯ Significant increase in cost of daycare expenses by a provider who is not the employee's relative

◯ Change in daycare provider or hours of care

◯ Spouse changes dependent care FSA election under enrollment window in spouse's employer's plan

Date of Qualifying Event: _____

## 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 Qualifying Events such as changes in family or other status as described above. I further certify that any Dependents for whom I will be claiming reimbursement for Dependent care or health care expenses would qualify as my Dependents under the tax code, as explained in the summary plan description. 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 this form.

With respect to the Health Care Spending Account, I understand that if I fail to provide information to satisfy CDPHN that amounts paid by use of the FSA debit card are eligible health care expenses, that CDPHN will take whatever action it deems appropriate to require that I repay the amount that has not been verified, including: (i) requesting that I reimburse the Plan for the amount that has not been verified; (ii) suspending my access to the Health FSA funds; (iii) offsetting future medical reimbursement claims by the amount paid by use of the debit card that has not been verified; (iv) suspending my eligibility to participate in the Plan; and (v) deducting from my taxable wages the amount of the expense paid by use of the stored value card that has not been verified.

_____ _____

Employee Signature Date

## *For Employer Use—Please complete before forwarding to CDPHN*

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

Other Notes: _____

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# 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 the Plan and 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, including the creation of an Organized Health Care Arrangement (OHCA) that permits sharing of my medical plan claims information with the Health FSA.

## Debit Card

I certify that I will only use the Plan debit card to purchase eligible health 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 e-mail 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**