benefit strategies LLC

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FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

A. Employee Information *Please Print Clearly!*

Name: _____ Social Security Number (Required): _____

Home Address: Check if New: ☐ _____

City: _____ State: _____ Zip Code: _____ Day Phone: _____

E-mail Address (Required): _____ Date of Birth: _____

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Reimbursement Account Eligible health expenses include professional medical 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		=	$
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Election allowed
$2,850
Minimum allowed
$250.00

2. Dependent Care Assistance Account Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

$	X		=	$
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Election allowed
$5,000
($2,500 if married filing separately)

C. *FlexExpress*© Debit Card A set of 2 FlexExpress Cards© will be mailed out to you automatically. If you would like additional cards for your dependents, please indicate your selection below.

☑	I FlexExpress Cards© Debit Card	You will automatically receive a set of 2 FlexExpress Cards©

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

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):		Benefit Effective Date:	

If this is a mid-year enrollment provide hire date and first payroll date for deductions.	Hire Date:	First Payroll Date:

FSA Eligible Expense List

Health FSA Eligible Expenses

Over-The-Counter Medicines and Drugs no longer require a prescription

PPE For Covid-19 Protection**

Ace bandages
Acne treatments
Acupuncture
Allergy and sinus medicine
Antacids and digestive aids
Antibiotic ointments
Antifungal and anti-itch
Aspirin and other pain relievers
Asthma medicine
Athletic treatments
Band-aids
Blood pressure monitors
Canker and cold sore remedies
Chest rubs
Chiropractic care
Cholesterol meter test kit and supplies
Cold and flu medicines
Contact lenses
Contact lens cleaning solution
Co-insurance
Contraceptive devices and family planning products
Copays
Corn and callus removers
Cough medicine
CPAP machine
Crutches, canes and walkers
Deductibles
Dental care (routine and corrective)
Dentures
Diabetic monitors and supplies
Diaper rash ointments
Eye exams
Eye glasses
Eye related equipment
First aid kits
Gastrointestinal medication
Genetic testing*
Glucosamine
Group therapy
Hand Sanitizer**
Hearing aids and batteries
Hearing care
Herbal medicine*
Hospitalization costs
Hypnosis – treatment of illness
Immunizations
Imaging scans
Incontinence supplies
Individual therapy
Laboratory fees
Lasik eye surgery
Laxatives
Lice treatments
Masks**
Massage therapy*
Medical equipment
Medical monitoring and testing
Menstrual care products (tampons, pads, etc.)
Mileage to receive medical care
Motion and nausea medicine
Nutritional supplements*
Orthodontia
Orthopedic and surgical supports
Orthotics
Physical exams
Physical therapy
Physician services
Pregnancy tests
Prescription drugs
Psychoanalysis and mental health therapy
Reading glasses
Sanitizing wipes (surface wipes are not eligible)**
Sleep aids
Smoking deterrents
Sunscreen (SPF 30 and higher)
Thermometers
Toothache gels
Urological products
Vision care
Vitamins*
Wart removal treatment
Weight loss drugs and programs*
Wheelchairs and repairs

If you have questions on what constitutes an FSA eligible expense, please contact our Customer Relations Team through online chat, 1-888-401-FLEX(3539) or email info@benstrat.com.

Ineligible Expenses Examples

- Cosmetic Surgery & Procedures
- Health Club Dues
- Insurance Premiums
- Dental Hygiene Products

*Dual Use items and services are those that can be used for general health as well as to treat an illness or physical defect. If the item/service is prescribed to treat an illness or physical defect, a Physician Statement form needs to be submitted to Benefit Strategies for it to be FSA eligible. This form can be found on benstrat.com, or by contacting our Consumer Relations team. Dual Use items/services will not work with the Benefit Strategies Debit card. You will need to pay with another means and submit for reimbursement through one of our reimbursement methods. Remember to submit the Physician Statement, along with the purchase documentation.

Election Worksheet

The Health FSA and Dependent Care FSA Election Worksheets can help you determine how much to set aside in your FSA. You can also use the Tax Savings Calculator at **benstrat.com.**

Important: Make a conservative election, only considering expenses that are expected to be incurred by you and your FSA eligible dependents while you are enrolled during the FSA plan year.

Health FSA Worksheet

Health Care Expenses Per Plan Year	For You	For Your Spouse	For Your Children
Dental Deductibles	**$**	**$**	**$**
Dental Work	$	$	$
Orthodontia	$	$	$
Eye Exams, LASIK Surgery	$	$	$
Prescription Eyeglasses, Reading Glasses, Contact Lenses	$	$	$
Vision Solutions and Supplies	$	$	$
Medical Deductible	$	$	$
Medical Copays	$	$	$
Prescription Drugs	$	$	$
Over-The-Counter (OTC) products, including medicines and drugs	$	$	$
Medical Supplies	$	$	$
Chiropractic Care and Acupuncture	$	$	$
Total each family member column	(A)$	(B)$	(C)$
Total cost of health care expenses for the plan year (A)+(B)+(C)	(D)$		
Enter the maximum permitted Health FSA election This can be found on your FSA Enrollment Form	(E)$		
Election amount. Enter (D) or (E), whichever is less Also enter this amount on your FSA Enrollment Form	(F)$		
Number of pay periods in a plan year	(G)		
Payroll deduction amount per pay period (F)÷(G)	$		

Dependent Care FSA Worksheet

Eligible weekly dependent care cost	**(A)$**
Weeks of dependent care you will have in the plan year	**(B)$**
Total cost of dependent care for the plan year (A) x (B)	**(C)$**
Enter the maximum permitted Dependent Care FSA election This can be found on your FSA Enrollment Form	**(D)$**
Election amount. Enter (C) or (D), whichever is less Also enter this amount on your FSA Enrollment Form	**(E)$**
Number of pay periods in a plan year	**(F)**
Payroll deduction amount per pay period (E) ÷ (F)	**(G)**