



ENROLLMENT FORM

FLEXIBLE SPENDING ACCOUNTS

WITH

BENIVERSAL® MASTERCARD®

(PLEASE PRINT CLEARLY)



2320 Brighton-Henrietta Townline Rd
 Rochester, NY 14623
 Phone: (800) 473-9595
 Website: www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID (typically your SSN):

Employee Name: (Last) _____ (First) _____ (MI) _____

Home Address: (Street) _____ (Apt #) _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone #: _____ E-mail Address: _____

Hire Date: / / Birth Date: / / Gender: Male Female

Employee Status: Full-Time Part-Time

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary needed to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with Section 125 of the Internal Revenue Code.

B. BENIVERSAL CARD – SAVE ALL RECEIPTS! This section must be completed (please check only one box).

*Employer
use only*

Please send me a Beniversal Card to use only for qualified medical expenses (I am not a current cardholder). **NOTE: You must provide E-mail address above to receive a card.**

C

I **DO NOT** want a Beniversal Card (I am not a current cardholder).

N

I will continue to use my current Beniversal Card through the expiration date on the card as long as I am enrolled in the Plan.

Y

Cancel my current Beniversal Card. I understand the card can no longer be used and should be destroyed by me.

X

C. FLEXIBLE SPENDING ACCOUNTS Please enter your FSA election(s).

(Refer to your Plan Highlights for election maximums)

Per Pay Deduction

Plan Year Election

Medical Flexible Spending Account \$ _____ \$ _____

Dependent Care Flexible Spending Account \$ _____ \$ _____

D. EMPLOYEE CERTIFICATION

- I have received and read the printed material which explains my Plan and my options under it. I understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current Plan Year. Any choices above may be modified only as defined in the Plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that any unused amounts in either Flexible Spending Account will be forfeited after the timeframe indicated in the Plan Highlights.
- If elected, I authorize the issuance of a Beniversal® MasterCard® by a bank chosen by Benefit Resource. I agree to use this card only for eligible medical expenses under the Plan for me or a qualifying individual and to be bound by all provisions of the Beniversal *Cardholder Agreement* and *My Use of Card Promises* sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the *Agreement*, I may lose Beniversal Card privileges and will reimburse the Plan for the expenses. I authorize my Employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize replacement card expenses to be deducted from my account balance.
- I understand that Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my Beniversal Card. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.
- Since the IRS requires substantiation for certain purchases made with the Beniversal Card, I agree to acquire and retain sufficient documentation for any expense paid with the Card and to submit such documentation to Benefit Resource upon request.

Signature: _____ Date: ____ / ____ / ____

E. PAYROLL DEDUCTION INFORMATION Employer must complete this section for employee to be enrolled.

• **Deduction cycle:** weekly bi-weekly monthly semi-monthly other _____

• **Pay Date of first FSA deduction(s):** ____ / ____ / ____

• **Number of pay dates on which FSA deduction(s) will be taken during this Plan Year:** ____

• **Health Insurance Carrier:** _____ **Health Insurance Plan Name:** _____

Note: If employee is not insured through employer Plan(s), enter *No Coverage*.

Please return completed form to your employer.

The Employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.