



GROUP INSURANCE COMMISSION
Flexible Benefit Plan Enrollment Form



Plan Year: July 1, 2017 to June 30, 2018
 2½ Month Grace Period: July 1 - September 15, 2018
 Claim Filing Deadline: October 15, 2018

EMPLOYEE: Fill out Sections A through E and return completed form to your Payroll/Benefits Coordinator

A. Employee Information – Please Print Clearly!

Name: _____ Social Security Number (Required): _____
 Address: _____ Daytime Phone: _____
 City: _____ State: _____ Zip Code: _____
 Employee ID#: _____ Date of Birth: _____ Agency Name: _____
 E-mail (Required): _____

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Spending Account (HCSA) Eligible health expenses include medical, dental, vision and hearing 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." See IRS Publication 502 for more information.

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

Election Allowed per Plan Year
 \$250 minimum/\$2,600 maximum

2. Dependent Care Assistance Program (DCAP) Eligible dependent care expenses must be work-related and incurred to allow me and, if applicable, my spouse to be gainfully employed. Qualifying dependents include children under age 13 or older dependents who are not capable of self-care. 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. See IRS Publication 503 for more information.

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

Maximum Election Allowed per Tax Year
 \$5,000 / \$192.30/Biweekly pay period
 (\$2,500 if married and filing separately)

C. ASIFlex Card HCSA participants will automatically receive two debit cards. A \$5.00 fee will be assessed annually for additional/replacement card sets and billed directly to your HCSA. Please indicate the number of additional card sets you would like to request below. (You will automatically get 2 cards to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.)

Additional Card Sets Requested: _____

REQUIRED: You must indicate the medical plan in which you have enrolled. Please check the appropriate box. If not enrolled in a GIC plan, check the last box.

- | | |
|--|---|
| <input type="checkbox"/> Fallon Health Direct Care HMO | <input type="checkbox"/> Tufts Health Plan Navigator POS |
| <input type="checkbox"/> Fallon Health Select Care HMO | <input type="checkbox"/> Tufts Health Plan Spirit EPO (HMO-Type) |
| <input type="checkbox"/> Harvard Pilgrim Independence Plan POS | <input type="checkbox"/> UniCare State Indemnity Plan/Basic |
| <input type="checkbox"/> Harvard Pilgrim Primary Choice Plan HMO | <input type="checkbox"/> UniCare State Indemnity Plan/Community Choice (PPO-type) |
| <input type="checkbox"/> Health New England HMO | <input type="checkbox"/> UniCare State Indemnity Plan/PLUS (PPO-type) |
| <input type="checkbox"/> NHP Care (Neighborhood Health Plan) | <input type="checkbox"/> Not enrolled in any plan listed |

D. Direct Deposit Authorization Claim payments can be sent directly to a bank account of your choice, and you can be notified by email/text alert each time a payment is issued.

Bank Name: _____
 (See #1 on sample) Checking Account
 Savings Account

Routing Number - 9 digits: _____
 (See #2 on sample)

Account Number: _____
 (See #3 on sample)

Cell Phone: _____ **Mobile Carrier:** _____



E. Signatures By signing below, I agree to the following Terms and Conditions stated on the opposite side of this form.

Employee Signature (Required): _____ **Date:** _____

REQUIRED: The section below must be completed, in full, by agency Payroll/Benefits Coordinator

| | | | |
|--------------------------------------|---|-------------------------------------|-------------|
| Benefit Effective Date: | DCAP: ___/___/___ HSCA: ___/___/___ | Date of Qualifying Event: | ___/___/___ |
| Payroll/Benefits Coordinator: | | Division Code: (ex: ABC1234) | ___/___/___ |
| Email Address: | | Phone #: | |
| Reason for Enrollment: | <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Status Change: _____ | | |

PAYROLL/BENEFITS COORDINATORS: Fax or Upload completed form to ASIFlex, not the GIC

Enrollment Form Instructions

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|------------------|--|
| Section A | Employee Information - Please print your name and complete address clearly. Your phone number and e-mail address will be used only to communicate with you with regard to this plan. It will not be distributed to any other organization or used for marketing purposes in any way. Statements of your account balance and activity will be sent via e-mail/text alert whenever possible. Please understand that this is an employee account and due to federal and state laws we cannot release detailed information to anyone other than the participant (employee). Please contact our office for further information or you can sign a HIPAA release to allow others to act on your behalf and obtain information. |
| Section B | Flexible Benefit Pre-Tax Elections - <ol style="list-style-type: none"> 1. Health Care Spending Account (HCSA) - Carefully consider how much money you would like to set aside each pay period during the Plan Year to pay for your family's eligible out-of-pocket medical expenses. Make sure you read your Participant Handbook to fully understand how the plan works. 2. Dependent Care Assistance Program (DCAP) – Carefully consider how much money you would like to set aside each pay period during the Plan Year to cover the expenses you will incur to care for your eligible dependents while you and your spouse (if applicable) are gainfully employed. Qualifying dependents are children under age 13 or older dependents not capable of self-care. Make sure you read your Participant Handbook to fully understand how the plan works. |
| Section C | ASIFlex Card - You may order an additional set of cards for other eligible dependents if desired. A fee of \$5.00 per additional set will be assessed to your HCSA for each set of cards. Cards are reloaded over plan years, so if you already have a debit card from a prior plan year, it will be loaded with your election funds. You will not receive new cards unless requested. |
| Section D | Direct Deposit Authorization - If you would like your reimbursements sent directly to your checking or savings account via Direct Deposit, fill out this section and attach a voided check (for checking) or deposit slip (for savings). Confirmations are sent via email/text alert and will show current transaction information, as well as, available funds in the account. |
| Section E | Signatures - After you have completely filled out this form and carefully read the following Terms and Conditions please sign and date then return the enrollment form to your payroll office as applicable. Employers must review the elections and sign that the employee meets the eligibility requirements. |

Flexible Benefit Plan Terms and Conditions

I UNDERSTAND THAT:

- By participating in the Flexible Benefit Plan, my employer will deduct pre-tax from my pay check: \$2.50 per month from the first paycheck of each month and my election amount equally divided by the number of pay periods within the plan year.
- I cannot change this election during the Plan Year unless I have a qualifying change in status as described in the Plan document.
- I must make all of my elections carefully and conservatively. The IRS imposes a strict “use-it-or-lose-it” rule, which means money left in a pre-tax account at plan year end is forfeited.
- Expenses paid under the HCSA or DCAP cannot be reimbursed from any other source and that I will not seek reimbursement from any other source.
- Expenses must be incurred during the Plan Year or the Grace Period. The Grace Period is a 2 ½ month period following the end of the Plan Year during which I may continue to incur expenses for the prior plan year. (September 15, 2018)
- All FY18 plan year claims must be submitted by the claim filing deadline, called a run-out period, which ends October 15, 2018. The IRS imposes a strict “use-it-or-lose-it” rule, which means money left in a pre-tax account at the plan year end is forfeited.
- Qualifying expenses are those incurred by me, or by my legal dependents.
- HCSA expenses can be reimbursed up to the plan year election, less prior reimbursements. DCAP expenses can be reimbursed up to the year-to-date deposits, less prior reimbursements.
- The ASIFlex Card can be used only for qualifying health care expenses as defined by IRS guidelines. The IRS requires me to keep documentation of all my card transaction expenses and submit documentation to the administrator upon request. If I do not provide the requested documentation as required, IRS regulations require that the card be temporarily deactivated. Claims submitted will be offset by any outstanding card transaction amount. Misuse of the card may result in permanent revocation and repayment of ineligible expenses.
- If I have not selected to be reimbursed by Direct Deposit, I am accepting to receive reimbursement check by mail to my address on file. I understand that reimbursements will accumulate until a minimum of \$25.00 is met. A reimbursement check will not be issued for an amount below \$25.00; unless the plan year has ended.
- I understand additional details are outlined in participant handbook available at asiflex.com/gic.

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Toll-free: 1-800-659-3035 | Fax: 1-877-879-9038 | E-mail: asi@asiflex.com
www.asiflex.com/GIC

Important Information Regarding Enrollment and Changes

ADMINISTRATIVE FEE

The cost to administer this program is paid for by each employee on a before tax basis. The monthly administrative fee is \$2.50 for any account participation – for Health Care Flexible Spending Account (HCSA) alone, Dependent Care (DCAP) alone or for HCSA/DCAP combined.

ELIGIBILITY AND ANNUAL MAXIMUM AND MINIMUM FOR HCSA AND DCAP

HCSA: Active state employees who are eligible for GIC benefits. Enrollment must be elected within 10 days from your date of hire. The waiting period is the same as for other GIC life and health benefits; coverage effective the first of the month following 60 days or 2 calendar months. Minimum \$250; Maximum \$2,600.

DCAP: Active state employees who are eligible for GIC benefits who work at least 18.75 hours per 37.5 hour work week or 20 hours per 40 hour work week. You are eligible on the first day of employment. Enrollment forms must be submitted to your Payroll Coordinator within 10 business days from your date of hire. Maximum \$5,000 at beginning of plan year, \$192.30 per biweekly pay period mid-year (\$2,500 if married filing separately).

CHANGE IN STATUS

Elections may be changed during open enrollment. You may only change your election mid plan year if you experience a “change in status” as defined in the Plan. Only the following events will be considered a valid change in status under Internal Revenue Service rules.

- Change in legal marital status
- Change in number of dependents
- Change in employment status that changes your eligibility for the program
- Change in work schedule, which changes your eligibility for the program
- Dependent satisfies or ceases to satisfy eligibility requirements
- Judgment decree or order pertaining to child or spouse

If you would like to terminate your elections as a result of a valid change in status, enter a zero dollar amount in the HCSA/DCAP section(s) of the enrollment form. Payroll Coordinators must obtain the appropriate supporting documentation of a Change in Status, such as a copy of the marriage or birth certificate. Please see the current plan year Participant Handbook for additional information and information regarding Leaves of Absence and Leaving State Service. Forms must be submitted within 60 days of the qualifying event.

SIGNATURE AND FORM SUBMISSION

The employee and Payroll/Benefits Coordinator must sign this form. All forms must be submitted to the Payroll Office at your work site. The Coordinator must send the original form to ASIFlex. Please do not send completed forms to the GIC.

ELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN

Eligible expenses under a Dependent Care Assistance Plan are defined as those that are “work-related” as defined in the regulations and enable the participant and the participant’s spouse to work or to look for work, and are incurred for the protection and well-being of the dependent. Dependents must be under the age of 13 or, if older, not capable of self-care. Qualifying providers and expenses include:

- Child Care centers that care for six or more children and that meet the IRS’ definition of a qualified day care center.
- Caregivers for a disabled spouse or dependent who lives with the participant and is not capable of self-care.
- Babysitters for work-related expenses
- Before school or after school care
- Day Camp (not overnight camps)
- Household expenses provided that a portion of such expenses are incurred to ensure a qualifying dependent’s well-being and protection.

Note: Please see IRS Publication 503 additional information. In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19. IRS calendar year pre-tax maximum is \$5,000.

INELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN

- Expenses for services not yet provided, even if you must pay in advance
- Babysitting for social events, or services that are not “work-related” as defined by the IRS
- Educational or tuition expenses (kindergarten, first-grade or higher)
- Overnight camp, summer school, lessons (dancing, musical, etc.)
- Expenses incurred while you are not working or looking for work

Note: If you are divorced, only expenses incurred by the custodial parent may be considered

ELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT

Eligible expenses under a HCSA are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program. Eligible expenses are listed in the Participant Handbook available on the GIC’s web site, www.mass.gov/gic/fsa. Don’t forget that expenses such as insurance premiums may be deductible on Schedule A tax return, but not eligible for reimbursement through a HCSA. Some examples of eligible expenses are: acupuncture, ambulance, artificial limbs, contact lenses, health plan deductibles, dental expenses, health and RX co-pays, hearing aids, vision expenses, over-the-counter health care products, and more. Additional information is also located at www.asiflex.com/gic.

INELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT

- Expenses for services not yet provided, even if you must pay in advance
- Expenses paid under any other source (such as another insurance plan)
- Cosmetic treatments, medications or surgery (such as teeth whitening, face lifts, hair transplants, etc.)
- Expenses for general health and well-being (such as fitness programs, exercise equipment, health club memberships, etc.)
- Insurance premiums
- Expenses that are not properly substantiated.