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).*

☐ 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.

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

☐ I am a current Beniversal Cardholder and wish to keep my current card.

☐ Cancel my current Beniversal Card.

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.