Enrollment Form: Flexible Spending Account

P.O. Box 70168 ◆ Springfield, OR 97475
Phone (541) 485-7488 ◆ (800) 422-7038
FAX (541) 485-8759 ◆ (800) 575-1109
PacificSource.com/PSA

EMPLOYEE INFORMATION

Employer name: UMCHS, Inc.		Eligibility date: 10/1/2013	
Employee name: 18 pay period example		Date of birth:	
Mailing address:	City:	State:	Zip:
Home phone:	Work phone:		
Email address:			

ACCOUNT INFORMATION

Beneficiary*: _____ Relationship: _____

*Please designate someone over the age of 18 to be the beneficiary for your account. This person will be responsible for submitting claims in the event you are not physically able to do so. The beneficiary does not need to be related to you.

Payroll Deducted Group Insurance Premiums: ☐ Yes ☐ No ☐ N/A $ _____ fee per pay period

Benny® Card Enrollment: ☐ Yes ☐ No $ _____ fee per month

I request the following amounts to be reduced from my paycheck:

	Per Pay Period Amount	Annual Amount	
Dependent Care Expenses	$	$	☐ Not applicable
Unreimbursed Eligible Health-Related Expenses	$133.33	$2400	☐ Not applicable
Other Health-Related Insurance Premiums	$	$	☐ Not applicable
Administrative Fee	$	$	☐ Not applicable
TOTAL AUTHORIZED REDUCTIONS	$	$	

PREMIUM AGREEMENT FOR UNREIMBURSED HEALTH-RELATED EXPENSE ACCOUNT

Please Check One:

☐ I *am* participating in the Unreimbursed Health-Related Expense Account. *Please read the following and sign below.*

☐ I *am not* participating in the Unreimbursed Health-Related Expense Account. *Do not sign below.*

I agree to participate in the Unreimbursed Health-Related Expense Account for the entire Plan Year. I understand that if my employment is terminated prior to the end of the Plan Year, the remaining monthly premiums will be taken from my final paycheck on a pre-tax basis, or in the alternative I agree to reimburse my employer (on a monthly basis) with after-tax dollars. If my final paycheck does not cover the remaining contributions, I agree to reimburse my employer the remaining balance (on a monthly basis) with after-tax dollars. I further understand that I have through the end of the Plan Year to incur eligible expenses, and may request reimbursement through the end of the normal run-out period as described in the Summary Plan Description.

Signature: _____ Date: _____

Sign here *only* if you are participating in the Unreimbursed Health-Related Expense Account.

AUTHORIZATION

I hereby certify the above information to be correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the Plan Year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the Plan Year and cannot be revoked unless I experience a qualified change in status. I also understand that the above reductions may correspondingly reduce my future Social Security benefits.

Signature: _____ Date: _____

Participant: Return original to your employer and retain a copy for your records. **Employer:** Forward a copy to PacificSource Administrators.