



Name (Please Print) Last		First	MI	Employee ID or Social Security #	
Home Address Street		City	State		ZIP
Daytime Phone ()	Home Phone ()	Date of Hire	Date of Birth	Annual Salary	
E-mail Address					
ENROLLMENT STATUS: <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> RE-ENROLLMENT <input type="checkbox"/> CHANGE IN STATUS <input type="checkbox"/> NEW HIRE					
CHANGE TYPE: _____ DATE: ____/____/____					

- Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
- Health care spending account and dependent care spending account worksheets are available at www.myfbmc.com as well as the following DAS webpage das.ohio.gov/FlexibleSpendingAccount
- If you have questions, consult your 2010 Flexible Benefits Plan Open Enrollment Brochure, or call FBMC Customer Service at 1-800-342-8017.
- Be sure to submit your enrollment form by October 30, 2009.
- Your effective date of participation will be January 1, 2010.

In Box #1, indicate the dollar amount you will contribute for the 2010 plan year.
 In Box #2, indicate the number of regular payroll checks you expect to receive during the 2010 plan year.
 In Box #3, indicate the deduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.)

By signing this form you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement or any other anticipated unpaid leave.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)
Use your Health Care FSA for eligible uninsured, out-of-pocket medical expenses incurred by you, your family members or both. (Annual allowable maximum contribution per participant is \$3,000)	TAX FILING STATUS – PLEASE CHECK ONE:
	<input type="checkbox"/> Married, filing separately [\$2,500 maximum] <input type="checkbox"/> Married, filing jointly [maximum - \$5,000] <input type="checkbox"/> Single, head of household [maximum - \$5,000]
Box #1 Total plan year dollar amount from your worksheet _____	Box #1 Total plan year dollar amount from your worksheet _____
Box #2 24 for employees paid bi-weekly 12 for employees paid monthly ÷ _____	Box #2 How many consecutive pay periods for payroll deduction? _____ Employees paid bi-weekly (max of 24) _____ Employees paid monthly (max of 11) ÷ _____
Box #3 Reduction per regular paycheck = _____	Box #3 Reduction per regular paycheck = _____

All health care spending account participants will receive a myFBMC Card to facilitate accessing their accounts. This health care spending account debit card does not have a fee.

- IMPORTANT**
- I hereby authorize my employer to reduce my gross salary before Medicare, local, state and federal income taxes are calculated by the total amount of annual salary deduction indicated above.
 - I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
 - I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
 - I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
 - I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with the contract administrator within 30 days of the event.
 - I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
 - I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from and I specifically release them from my participation in any FSA or my failure to sign or accurately complete this Enrollment Form.
 - I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE SIGNED
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SUBMIT YOUR COMPLETED FORM TO FBMC AT P.O. BOX 1878, TALLAHASSEE, FL 32303.

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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*To Do:
 Sign up for 2010
 Flexible Spending
 Account!*



FLEXIBLE SPENDING ACCOUNT

Sign Up!

Open Enrollment • October 5 thru October 30, 2009

OhioDAS | **Ohio** The State of Perfect Balance
Ohio Department of Administrative Services

What is an FSA?

Flexible Spending Accounts, or FSAs, allow you to avoid paying local, state, federal and Medicare tax on dollars you use to pay eligible health care and dependent care expenses. You choose how much you want to put into your Flexible Spending Account.



For example, if you pay a \$100 co-pay for eyeglasses with money from your Flexible Spending Account, you are really only paying about \$80 to \$85 in out-of-pocket expenses. If the \$100 had been taxed, you would only receive \$80 to \$85 net pay in your paycheck, depending on your tax bracket.

Putting money in a Flexible Spending Account to pay for health care expenses or to pay for childcare or other dependent care expenses saves you money!

FSA 2010 • Page 12

2010 FSA Notes

How to Enroll in a Flexible Spending Account

- Visit das.ohio.gov/FlexibleSpendingAccount OR
- Complete and detach the enclosed enrollment form on this mailing and mail to:

FBMC
P.O. Box 1878
Tallahassee, FL
32303-1878

Do This ASAP

Am I eligible for a FSA?

You are eligible for the Health Care Spending Account Program if you meet the following requirements:

- You are a permanent employee and eligible for health care coverage, whether or not you are enrolled in a State of Ohio health plan.
- You are eligible once you have completed your probationary period.

You are eligible for the Dependent Care Spending Account Program if you meet the following requirements:

- You are a permanent full-time state employee.
- You have qualifying dependents.
- You are eligible on your date of hire.

What types of FSA are available to me?

The State of Ohio offers two flexible spending accounts:

- Health Care Spending Account (HCSA), and
- Dependent Care Spending Account (DCSA).

Health Care Spending Account

The health care spending account (HCSA) is a tax favored account, which provides the opportunity for eligible employees to defer up to a maximum of \$3,000 into an account to pay for eligible expenses not paid by their health care plan, vision or dental plan on a pre-tax basis. The myFBMC Card is provided to participating employees. It is a debit card which facilitates payment of eligible health care expenses.

Dependent Care Spending Account

The dependent care spending account (DCSA) is a tax favored account, which provides the opportunity for eligible employees to defer up to a maximum of \$5,000 (dependent on tax status) into an account to pay for eligible child care, dependent care, and elder care expenses on a pre-tax basis.

Customer service representatives are available Monday through Friday, 7 am - 10 pm est at 1.800.342.8017.

What are Qualifying Expenses. And, what's covered?

These "primarily medical" services/items are the types of expenses that normally qualify for reimbursement under a health FSA. A health FSA is typically funded with an employee pre-tax salary reduction.

Acupuncture
Adoption, pre-adoption medical expenses
Alcoholism treatment
Allergy Medicine (Examples: Alavert, Claritin)
Aspirin
Asthma treatment
Birth-control pills
Blood-pressure monitoring devices
Blood-sugar test kits and test strips
Carpal tunnel wrist supports
Chiropractors
Claritin (loratadine), an allergy drug
Co-insurance amounts
Cold medicine (Examples: Comtrex, Sudafed)
Contact lenses, materials, and equipment
Contraceptives
Co-payments
Cough suppressants
Crutches
Deductibles
Dental treatment
Diabetic supplies
Eye examinations, eyeglasses, equipment, and materials)
Fever-reducing medications (Examples: Aspirin, Motrin, Tylenol)
Flu shots
Glucose-monitoring equipment
Hearing Aids
Hospital services
Immunizations
Insulin
Laboratory fees
Laser eye surgery; Lasik
Lodging at a hospital or similar institution
Medical alert bracelet or necklace
"Morning-after" contraceptive pills
Nicotine gum or patches (Examples: Nicoderm, Nicorette)
Obstetrical expenses
Operations
Optometrist
Orthodontia
Oxygen
Physical exams
Physical therapy
Pregnancy test kits
Reading glasses
Sinus medications (Example: Sudafed)
Smoking-cessation programs
Stop-smoking program
Surgery
Taxes on medical services and products
Therapy
Transplants
Vaccines
Vision correction procedures
Walkers
Wheelchair
X-ray fees

HEALTH CARE FSA WORKSHEET

Eligible 2010 uninsured out-of-pocket medical expenses estimate

UNINSURED MEDICAL EXPENSES

Health insurance deductibles

\$ _____

Coinurance or co-payments

\$ _____

Vision care

\$ _____

Dental care

\$ _____

Prescription + Over-the-counter (OTC) Medications

\$ _____

Travel costs for medical care

\$ _____

Other eligible expenses

\$ _____

TOTAL

\$ _____

ADD annual administration fee (if applicable)

+ _____

DIVIDE by the number of paychecks you will receive during the plan year

÷ _____

This is your pay period contribution

\$ _____

Oct. 5th!

Fall Open Enrollment is scheduled October 5 - October 30, 2009. Enrollment elections become effective January 1, 2010. Employees who participated in an FSA during 2009 must re-enroll to participate in the FSA during the 2010 calendar year. If both husband and wife are permanent state employees, both may enroll for individual health care spending accounts. Look for the Summer Edition of Pathways and the monthly Pathways postcards for more fall open enrollment information.

I need to visit das.ohio.gov/FlexibleSpendingAccount to:

- Use the interactive calculator to estimate our 2010 eligible expenses
- Complete the HCSA calculation worksheet
- Complete the DCSA calculation worksheet (there's one available on the sidebar)
- Enroll!

There's even a no-fee debit card!

Check out the no-fee debit card option to make using your HCSA even easier!



How Much Can I Have Deducted from My Paycheck?

Health Care Spending Account (HCSA)

Minimum Annual Deposit: No Minimum
Maximum Annual Deposit: \$3,000

Dependent Care Spending Account (DCSA)

Minimum Per-Pay-Period Deposit: \$10 if paid biweekly / \$20 if paid monthly

Maximum Annual Deposit:

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If either you or your spouse earns less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

	With FSA	Without FSA	With FSA	Without FSA	With FSA	Without FSA
Annual Gross Income	\$35,000	\$35,000	\$50,000	\$50,000	\$75,000	\$75,000
FSA Deposit	-\$2,000	-0	-\$2,000	-0	-\$2,000	-0
Taxable Gross Income	\$33,000	\$35,000	\$48,000	\$50,000	\$73,000	\$75,000
Federal Taxes	-\$7,260	-\$7,700	\$10,560	\$11,000	\$16,060	\$16,500
Annual Net Income	\$25,740	\$27,300	\$37,440	\$39,000	\$56,940	\$58,500
Out-of-Pocket Expenses	-0	-\$2,000	-0	-\$2,000	-0	-\$2,000
Spendable Income	\$25,740	\$25,300	\$37,440	\$37,000	\$56,940	\$56,500
	SAVINGS \$440		SAVINGS \$440		SAVINGS \$440	

I can save almost \$500 in taxes!

Daycare is COVERED!