

SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Health Care Spending Account.

For Open Enrollment Only: You may enroll online at www.wageworks.com



HEALTH CARE

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

* Appropriate supporting documentation must be submitted with this form.

- Indicate the amount you wish to contribute through tax-free salary deduction by completing the section below.
- For assistance, complete the Health Care Spending Account worksheets available at das.ohio.gov/flexiblespendingaccounts.
- If you have questions, consult your Flexible Spending Accounts Reference Guide, or call **Customer Service at 1-855-428-0446**.
- Your effective date will be the first of the month after WageWorks approves your enrollment or January 1, 2020 if completed during open enrollment.

To be eligible, you must be a permanent full-time or permanent part-time employee who has successfully completed your initial probationary period (if applicable). Enrollment must occur within 31 days of eligibility or during the open enrollment period.

The Benefit Year is January through December

HEALTH CARE SPENDING ACCOUNT

Use your Health Care Spending Account for eligible uninsured, out-of-pocket medical expenses incurred by you, your family members or both. (Annual allowable minimum contribution per participant is \$240. The maximum contribution per participant is \$2,500.)

Total ANNUAL ELECTION amount \$ _____

Deductions will be taken the first 24 pay periods of the calendar year unless you are paid monthly. For mid-year enrollment, your election amount will be divided among the remaining of the first 24 calendar year pay periods.

LIMITED PURPOSE SPENDING ACCOUNT

Elect **only** if you are enrolled in or planning to enroll in a High Deductible Health Plan (HDHP) and contributing to a Health Savings Account (HSA). This account covers dental and vision expenses only. (Annual allowable minimum contribution per participant is \$240. The maximum contribution per participant is \$2,500.)

Total ANNUAL ELECTION amount \$ _____

Deductions will be taken the first 24 pay periods of the calendar year unless you are paid monthly. For mid-year enrollment, your election amount will be divided among the remaining of the first 24 calendar year pay periods.

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 the funds in one Spending Account cannot be used to reimburse expenses covered by another Spending Account.
- 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 calendar year or file an approved Change In Status Election Form with the contract administrator within 31 days of the event.
- I understand that the funds in any Spending Account 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 WageWorks, the contract administrator, will not incur any liability resulting from either my participation in any Spending Account or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming calendar year, unless otherwise provided by law.
- I certify that: 1) I will only use my Spending Account 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 Spending Account, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

By signing this form you certify that you expect to receive payroll deductions to support your annual election amount.

EMPLOYEE SIGNATURE	DATE SIGNED
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SUBMIT YOUR COMPLETED FORM TO P.O. BOX 14766, LEXINGTON KY 40512-4766 OR FAX TO 1-866-672-4780.