Eastern Kentucky University S125 Flexible Benefit Plan 2008 Enrollment Form

You will be making elections for the July 1, 2008 – December 31, 2008 SHORT Plan Year. After completing this form, please sign, date, and **return it to your Human Resources Department on or before the end of your enrollment period.**

If you have any questions, please speak with your human resource representative or contact Chard, Snyder & Associates at **(513) 459-9997, toll free (800) 982-7715, e-mail at reenroll@chard-snyder.com** or visit our **web site** at **www.chard-snyder.com**.

Employee Information

Employee Name

SSN - -

Address

City

State

Zip Code

Daytime Phone ( ) - ☐ Home ☐ Work

E-mail Address (For Automatic Email Notification of Claims, Payment & Account Status)

Pay Frequency (Check one) ☐ Bi-Weekly (26 pays) ☐ Faculty (20 pays) ☐ Semi-Monthly (24 pays)

Plan Elections

Healthcare Reimbursement Account
This is for out-of-pocket medical, dental and vision expenses.
Contribute up to $2,500 for the SHORT plan year

Do you elect to Participate? ☐ Yes ☐ No

Annual Election $__________

Dependent Care Reimbursement Account
This is for child and / or adult daycare expenses.
Contribute up to $5,000.00 for the SHORT plan year.

Do you elect to Participate? ☐ Yes ☐ No

Annual Election $__________

Group Health Insurance - *Employees participating in this plan already receive this benefit on a pre-tax basis. If you do not wish to continue pre-taxing this benefit, then please contact human resources to obtain a waiver form.*

Plan Authorization

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above) or they will be forfeited at the end of the 90-day grace period.
- I cannot change my mind once the Plan Year begins; my elections must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I also acknowledge the receipt of the HIPAA Privacy Notice.

Employee Signature Date

For Office Use Only

Date of Hire: ____________________

S125 FLEXIBLE BENEFITS PLAN
EXPENSE ESTIMATE WORKSHEET

MEDICAL EXPENSES

	Total Annual Expenses for the Current Plan Year				Estimated Annual Expenses for the New Plan Year
	Employee	Spouse	Dependents		
Deductibles	$ _______	$ _______	$ _______		$ ____________
Coinsurance and/or co-payments	$ _______	$ _______	$ _______		$ ____________
Medical expenses partially covered or not covered by insurance plan:					
Prescription drugs	$ ______	$ ______	$ _______		$ ___________
Physician & hospital costs	$ ______	$ ______	$ _______		$ ___________
Emergency service	$ ______	$ ______	$ _______		$ ___________
Vision & hearing					
Eyeglasses	$ ______	$ ______	$ _______		$ ___________
Contact lens (& solution)	$ ______	$ ______	$ _______		$ ___________
Other expenses	$ ______	$ ______	$ _______		$ ___________
Over the Counter Items	$ ______	$ ______	$ _______		$ ___________
Total Medical Expenses	**$ _____**	**+ $ _____**	**+ $ _____**	**= $ _______**	**$ ___________**

DENTAL EXPENSES

	Employee	Spouse	Dependents		
Deductibles	$ ______	$ ______	$ _______		$ ___________
Coinsurance and/or co-payments	$ ______	$ ______	$ _______		$ ___________
Dental expenses partially covered or not covered by insurance plan:					
Restorative services (i.e. fillings)	$ ______	$ ______	$ _______		$ ___________
Oral surgery (i.e. root canal)	$ ______	$ ______	$ _______		$ ___________
Orthodontics (braces)	$ ______	$ ______	$ _______		$ ___________
Prosthodontics (i.e. dentures)	$ ______	$ ______	$ _______		$ ___________
Over the Counter Items	$ ______	$ ______	$ _______		$ ___________
Total Dental Expenses	**$ _____**	**+ $ _____**	**+ $ _____**	**= $ _______**	**$ ___________**

TOTAL HEALTHCARE EXPENSES **$ ______** **$ _________**