FURTHER℠

Formerly SelectAccount®

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

January 1 – December 31, 2019 Calendar Year Plan

Location Name: _____

Employee Information – All enrollees must complete.

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Primary Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Date of Birth: _____ / _____ / _____

Account Information (Effective Date: Begins January 1 or 1st of the month following date of hire)

1. Medical Flexible Spending Account: ☐ **Waive participation**

DOW-R minimum $150; IRS maximum $2,650

☐ I want to contribute a total of $ _____ during this plan year to my Medical Flexible Spending Account.

I understand this amount will be deducted from my payroll throughout the plan year.

If enrolling in medical flex, you must check the Health Savings Account question below:

Do you or your spouse have a Health Savings Account (HSA) with another administrator?

☐ No ☐ Yes: Your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met. Contact "Further" to remove the limit when your deductible is met.

2. Dependent Care Flexible Spending Account: ☐ **Waive participation**

DOW-R minimum $150; IRS maximum: $5,000 ($2,500 if married but filing separate tax returns)

☐ I want to contribute a total of $ _____ during this plan year to my Dependent Care Flexible Spending Account.

I understand this amount will be deducted from my payroll throughout the plan year.

Debit Card – For new medical flex enrollees, complete this section

Once enrolled into flex, you will automatically be issued a debit card to use for reimbursement for your medical flexible spending account. Your debit card(s) will be mailed to the account holder address on file at "Further."

Current enrollees do not have to complete this section. Also, do not destroy previous card(s) unless you are issued a new card.)

Note: Employees new to medical flexible spending account: If you are requesting a debit card, please complete the section below. See "Further" website for more information www.hellofurther.com.

Debit Card Signature - I certify that such expenses will not be eligible for benefit payment by any other insurance carrier and that such expenses will not be manually submitted by me to this or any other reimbursement account when I use my debit card. I understand that any debit card transaction using funds other than HSA may be subject to proof of purchase documentation upon request by Further. Failure to respond will result in cancellation of the debit card and I must reimburse the plan with after-tax dollars. I also understand that by requesting a debit card for my dependents, I am authorizing them to have access to information regarding their specific debit card transactions

Debit Card Signature: _____ **Date:** _____

Print Name: _____

Enrollment Form Signature – All enrollees must sign/date

I have reviewed the above elections and understand that my choices will remain in effect for the entire Flex Plan year, unless I experience a change in status as defined by the IRS. It is also my understanding that any funds remaining in my account(s) at the end of the Plan year may be forfeited.

Participant Signature: _____ **Date:** _____

Questions? Contact Benefits (Julia Sandsness) at the Diocese of Winona-Rochester at (507) 858-1268 or email benefits@dowr.org or contact "Further" Leader Services at (651) 662-2320 or (888) 460-4013.

Benefit Office Effective Date: _____ Medical Mo Amt: _____ Dependent Care Mo Amt: _____