P.O. Box 43653 Louisville, KY 40253-0653 (502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 www.bmsllc.net

ELECTION FORM FOR THE FLEXIBLE BENEFIT PLAN

PLEASE COMPLETE ALL FIELDS ON THE FORM AND PRINT CLEARLY AND LEGIBLY

Employer_____ Employee Name _____

Social Security # _____ Date of Birth _____

Mailing Address _____ City _____ State_____ Zip _____

Home Phone (___) _____ E-mail Address _____

Debit Card Information for Participants: I understand that an FSA Debit Card will be ordered for me based on the election(s) indicated below. **NOTE**: I agree to use the Debit Card for only qualified medical and/or qualified daycare expenses. I understand that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I also understand that if a payment is made that is not for qualified expenses under IRS guidelines, or if I fail to provide adequate documentation to substantiate an FSA Card swipe, I will repay the Plan. If I fail to reimburse the Plan, I authorize the Plan Sponsor to withhold such non-qualified expenses, including taxes, penalties, fines, or surcharges, from my payroll to the extent permitted by law. I also understand that I am responsible for submitting all requested receipts to BMS to validate my card usage as required under IRS guidelines. Usage of the Debit Card at a qualified merchant does not negate the need to submit receipts per current IRS rules and regulations if requested and necessary. I agree to review my account online periodically at www.bmsllc.net to obtain information on open transactions that require substantiation. I realize that if I fail to respond to request for receipts within 60 days of the posting of the transaction, my Debit Card will be suspended. Full compliance and submission of required receipts will be necessary in order to reactivate my Card. Notification of open transactions will be *emailed* to the email address provided above or saved at my employee website at www.bmsllc.net. Also, the debit card agreement that is sent to me with my card outlines the individual participant's responsibility for proper use. *A valid e-mail address is a highly recommended for card use in order to be notified of items in need of receipts.* ***EXTRA CARDS****: If you wish to order extra cards for your spouse and/ or dependents, please visit your employee website at www.bmsllc.net or contact BMS after the start of the Plan Year. Must be for a qualified dependent under IRS rules and regulations. A fee of $1.50 per additional card issued will be deducted from your FSA.* **IMPORTANT: Before using a card, a participant must follow the instructions on the Card sticker to activate the card. If the card is not activated, transactions will decline at the point of sale.**

OPTION 1 GENERAL PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (General Health FSA) (Eligible if NOT enrolled in HSA.)

☐ **YES** I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays qualified out-of-pocket healthcare expenses not covered by my health and other insurance plans. (NOTE: The Plan Year Maximum is set by the employer – please refer to your employer's FSA plan documents in reference to the annual maximum. If you elect more than this amount, BMS will automatically reduce your election to the Employer set maximum.) I understand that I can only participate in this Plan if neither I or my spouse are not currently enrolled in a HDHP/HSA Health Plan. If I am enrolled in the HDHP/HSA Plan, I can only participate for claims incurred *after* I satisfied my HSA Deductible under my qualified HDHP. **Or, if I elected NOT to enroll in the HSA Plan, I can participate without restrictions.**

☐ **NO** I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (Limited Health FSA) (Eligible if enrolled in HSA.)

☐ **YES** I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays qualified dental and vision out-of-pocket healthcare expenses not covered by my health and other insurance plans. I understand that I can participate in this Plan if I am currently enrolled in my Employer HDHP/HSA Health Plan and that I cannot seek reimbursement under my HSA Account for these same expenses, which include only qualified dental and/or vision expenses.

☐ **NO** I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 3 DEPENDENT CARE ASSISTANCE PLAN (Dependent Care FSA)

☐ **YES** I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays qualified dependent care expenses. Maximum amount per calendar year is the lesser of: (1) $5,000 for married filing jointly or $2,500 if married filing separate, (2) your spouse's total annual compensation or (3) half of your total annual compensation. If you are single, the maximum amount is $5,000.

☐ **NO** I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 4 AGREEMENTS TO SAVE TAXES ON INSURANCE PREMIUMS

☐ **YES** On the appropriate benefit enrollment forms, I have enrolled in certain employer-sponsored insurance benefits (i. e. health, dental, vision insurance and other qualified pre-tax benefits.) I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

☐ **NO** I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

My employer and I agree that my taxable income will be reduced during the year by an equal portion of the benefit elections (1-4) set forth above and that qualified expenses will be paid on a tax-free basis, I understand that I may change my election only in the event of certain changes in my status and that, prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I can review the Summary Plan Description available through my Employer. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: _____ **Date**_____

MUST COMPLETED BY EMPLOYER

Effective Date of FSA Participation (mm/dd/yy) ____/____/____ & end ____/____/____
Dept_____ First payroll start date ____/____/____ Pay Cycle _____