Horace Mann
Founded by Educators for Educators

Please return this form to your Employer: Mt. Blue RSD #9 - July - #50129

Enrollment Form: Flexible Spending Account(s)

Plan Start Date – Plan End Date

7/1/2021 | 6/30/2022

GENERAL INFORMATION

Employee Name: _____ SSN: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Date of Hire: _____

FLEXIBLE SPENDING ACCOUNTS

- ☐ I elect to participate in the Flexible Spending Accounts and employer-sponsored benefit coverage.
- ☐ I elect to participate in the Flexible Spending Accounts only.
- ☐ I elect to participate in the employer-sponsored benefit coverage only.
- ☐ I do not wish to participate in the Flexible Spending Accounts or employer-sponsored benefit coverage.

	Max Amount	Per Pay Period	# Pay Periods	Annual Election
Health Care FSA	$ 2,750.00	_____	**x** _____	**= $** _____
Dependent Care FSA	$ 5,000.00	_____	**x** _____	**= $** _____

(Day care expenses incurred during employment hours)

SUPPLEMENTAL PRODUCTS - *Additional protection in the event of an unexpected illness or accident*

I am interested in getting more information on the following supplemental products:

- ☐ Cancer Insurance
- ☐ Accident Insurance
- ☐ Hospital Insurance

AUTHORIZATION & ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

_____ _____

Employee Signature Date

HealthEquity/WageWorks is the administrator of your Plan.