Flexible Spending Account with Debit Card

Enrollment or Change Request

Please complete both pages of this form.

Employer Name	Plan Year Start Date

Section 1: Reason for Request *(check one)*

☐ **Regular Annual Election**

☐ **Mid-Year Election** Effective Date: _____ Date of first Payroll Deduction: _____

☐ **Change in Family Status** Date of Event: _____ Date of first Payroll Deduction After Change: _____

- ☐ Divorce/separation
- ☐ Death of spouse or child
- ☐ Change in work hours
- ☐ Marriage
- ☐ Spouse became unemployed
- ☐ Unpaid leave of absence
- ☐ Birth or adoption of a child
- ☐ Spouse ceases to be employed
- ☐ Other *(explain)* _____

Section 2: Employee Information *(please print)*

Name *(Last, First, Middle Initial)*	Date of Birth	Social Security No.

Street Address	Employee ID No.

City	State	Zip Code	Phone No. ( )

Email Address

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

Payroll Cycle ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Bi-monthly

Section 3: Family Members Associated with this Flexible Spending Account (FSA)

Name		Date of Birth	Social Security No.
	☐ Spouse ☐ Dependent ☐ Issue Debit Card for this individual		
Dependent Name	☐ Issue Debit Card for this individual	Date of Birth	Social Security No.
Dependent Name	☐ Issue Debit Card for this individual	Date of Birth	Social Security No.

Section 4: Enrollment and Reimbursement Account Election

I authorize my employer to deduct pre-tax contributions from my compensation for the following benefits:	**Annual Pre-Tax Deduction Election**	*To Be Completed by Employer's Human Resources Dept.* **Date of First Payroll Deduction**	**Per Pay Period Pre-Tax Deduction**
☐ **Medical Reimbursement Account** *(Reimbursement for family health care expenses not paid from any other source)*	$		$
☐ **Dependent Care Reimbursement Account*** *(Reimbursement for daycare expenses for eligible dependents)*	$		$

**If you are married and file federal income taxes jointly, the maximum annual dependent care contribution amount is $5,000. If you are single, or are married and file separate tax returns, the maximum annual dependent care contribution amount allowed is $2,500. Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.*

☐ **Yes, I would like to receive reimbursements through direct deposit to a checking or saving account.**
(If selecting this option, please complete the *Direct Deposit Authorization for MVP Flexible Savings Accounts* and/or *Health Reimbursement Arrangements* form and return it to MVP Health Care* with this completed form. You can obtain the form from your Employer or by emailing **myspendingaccounts@mvphealthcare.com**.)

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Employee Name

Section 5: Employee Authorization of Participation

By signing this form, I authorize my employer to reduce my pay on a per pay period basis as indicated on page 1. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

I understand that upon enrollment I will receive an MVP CareFund Debit Card and I agree that this card is only to be used to pay for qualified medical expenses that will not be reimbursed from another source, and that I am still responsible to acquire and retain documentation to substantiate any expenses paid for with the MVP CareFund Debit Card. All dependents must be age 18 or over to receive the MVP CareFund Debit Card. Debit cards will be mailed to your home address in a plain envelope. If you previously added a dependent, they will automatically be linked to the plan each year. It is your responsibility to notify the plan once a dependent is no longer eligible or if you with to terminate them from the plan.

I have read and agree to this authorization.

Employee Name *(print)*	Signature	Date

Employer Human Resources Representative Name *(print)*	Signature	Date

Questions? We're here to help. Call 1-888-222-9931.

Please return this completed form to:

By mail: ATTN: MVP ANCILLARY SERVICES
MVP HEALTH CARE
PO BOX 2207
SCHENECTADY NY 12301-2207

By email: myspendingaccounts@mvphealthcare.com