EDUCATORS MUTUAL INSURANCE ASSOCIATION

FLEXIBLE SPENDING ACCOUNT ENROLLMENT/CHANGE FORM

852 Arrowhead Lane • Murray, UT 84107 • (801) 262-7475 • (800) 662-5851 • www.educatorsmutual.com

Step 1: Employee Information

Employer	Date of Hire
Employee's Name	Date of Birth
Street Address	Social Security Number
City, State, Zip	Home Telephone
Email Address	Work Telephone

Step 2: Contribution Agreement

If you are part of a company health insurance plan, your insurance premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction. ~~There is an annual fee of $24 for this service.~~ (Do not include insurance premiums in the Health Care contribution below.)

❑ Health Care (medical, dental, vision) $ __________________ per year

❑ Dependent Care (child, elderly) $ __________________ per year

Use the worksheet on the back of this form to help you calculate your estimated eligible expenses.

❑ Initial Request

❑ New Year Request

❑ Mid-year Request
(Requires a qualifying event.)

Step 3: Health Care Debit Card

A Health Care Debit Card allows you immediate access to your Health Care FSA funds. Receipts or other forms of substantiation may be requested at a later date. Would you like a Health Care Debit Card? There is an annual fee of $19.80 for this service.

❑ Yes ❑ No

Step 4: Automatic Reimbursement

Automatic reimbursement is an option for employees who do not have coordination of benefits or the Health Care Debit Card. If eligible, do you want your processed Educators' claims automatically reimbursed?

❑ Yes ❑ No

Step 5: Employee Signature

Choose One:

❑ **Enrollment:** I hereby request enrollment in the Flexible Spending Plan. I authorize my employer, until this authorization is revoked in writing due to a change in employment or family status, to reduce my gross salary by the appropriate amount. I understand that amounts contributed to the Flexible Spending Accounts are subject to forfeiture procedures under Section 125 of the Internal Revenue Code. I will only use the Health Care Debit Card for eligible expenses under the plan, and I understand that I will be responsible to pay for any transactions not allowed by the plan.

❑ **Waiver:** I understand that I am eligible to participate in the Flexible Spending Plan, but elect not to do so at this time. I also understand that I may participate in the Flexible Spending Plan during the next available enrollment period.

Employee's Signature	Date
Employer's Signature	Date

Step 6: Optional Direct Deposit

You need only complete this portion of the application if you wish to have your FSA reimbursements deposited directly into your savings or checking account.

I hereby authorize Educators Mutual Insurance Association of Utah (EMIA) to deposit my Flexible Spending Account payments into my checking or savings account at my depository institution. This authority is to remain in effect until EMIA has received written notification from me that I wish to terminate the direct deposit benefit. I also agree to notify EMIA in writing within 30 days of any change in financial institution, account numbers, or status changes that may affect my eligibility to participate in Flexible Spending.

Name of Financial Institution	Phone Number
Checking or Savings Account Number (Please include a voided check.)	Routing Number
Employee's Signature	Date

Please return completed form to your employer.

FLEXIBLE SPENDING ACCOUNT WORKSHEET

Instructions	
	1. Enter your estimated annual eligible expenses for each health care option on the worksheet below. 2. Add up the Total Annual Health Care Expenses. 3. Enter this amount on Step 2 of your Educators Flexible Spending Account enrollment form under Health Care (see reverse side of this form). 4. Enter your estimated monthly eligible expenses for dependent care on the worksheet below. 5. Multiply by 12 (or by the number of months you expect to pay eligible dependent care expenses). 6. Enter this amount on Step 2 of your Educators Flexible Spending Account enrollment form under Dependent Care (see reverse side of this form).

Health Care Expense Worksheet

Medical Care	Insurance Deductibles	$ ________	
	Exam Copayments	________	
	Prescriptions	________	
	Lab Expenses	________	
	Medical Equipment	________	
	Chiropractor	________	
	Physical Therapy	________	
	Other	________	
	Total Annual Medical Care Expenses		**$** ________
Dental Care	Insurance Deductibles	$ ________	
	Dental Exams & Cleanings	________	
	X-rays	________	
	Fillings	________	
	Crowns	________	
	Other	________	
	Total Annual Dental Care Expenses		**$** ________
Orthodontic Care	Insurance Deductibles	$ ________	
	Orthodontia	________	
	Retainers	________	
	Other	________	
	Total Annual Orthodontic Care Expenses		**$** ________
Vision Care	Insurance Deductibles	$ ________	
	Eye Exams	________	
	Glasses	________	
	Prescription Sunglasses	________	
	Contacts	________	
	Contact Lens Solution	________	
	Other	________	
	Total Annual Vision Care Expenses		**$** ________
Health Care Total	**Total Annual Health Care Expenses**		**$** ________

Dependent Care Expense Worksheet

Dependent Care	Child Day Care Center	$ ________		
	Adult Day Care Center	________		
	Nursery School	________		
	Babysitting (while you work)	________		
	Other	________		
	Total Dependent Care Expenses	**$** ________ monthly expense	**X no. of months =**	**$** ________ annual expense

This worksheet is for your assistance; it is not required that you complete it as part of your application.