MEDCOST[SM]
BENEFIT SERVICES

Flexible Benefit Plan with Debit Card 20__ Plan Participation Form

Group Plan #: _____
Member Effective Date: _____

Company Name: _____

Employee Name: _____ **Employee ID #:** _____

Email Address: _____

Mailing Address: _____

_____

Hire Date: _____ **Birth Date:** _____

FLEXIBLE SPENDING ACCOUNTS

☐ **Request to Participate**

Benefit Elections

A.) Medical / Dental / Vision Care $ _____/Year
The cost paid by you and your dependents for annual deductibles, coinsurance, eye care, dental care, routine care, etc., which is not reimbursed by insurance

- are being selected for an entire Plan year;
- will be deducted from each paycheck on an equal basis; and
- may be changed only if certain changes occur in my family and/or employment status. (This change must be made within 31 days of the family status event and must be consistent with the event.)

I further understand that the total amount deducted for the reimbursement accounts must be used during the current Plan year or forfeited under the terms of the Internal Revenue Code (unless the Plan has been amended to allow for an extended grace period). In the event of termination of employment, expenses must be submitted within the time limit set by the Plan or reimbursement will be forfeited.

(If your spouse is a student or is incapacitated, contact your employer for the childcare limit that applies to you.)

☐ **Request to Waive**

The Flexible Benefit Plan has been explained, and I elect to waive participation in Flexible Spending Account. I understand that my next opportunity to enter the Plan will be at the start of the next plan year; however, if not changed, this wavier will continue in effect indefinitely.

*Newly participating members will receive two debit cards for use with their FSA account. If you have an existing debit card, please do not discard it unless instructed to do so by your employer or MedCost Benefit Services; your new contribution election amount will be added to your existing card.

Signature: _____ **Date:** _____

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