



CITY OF GREEN BAY Enrollment Form

- ✓ After completing this form, please sign, date, and return to your HR Department.
- ✓ If you have questions, please contact your Human Resource representative or contact Benefit Advantage at (800) 686-6829, or visit our website at www.BenefitAdvantage.com.

EMPLOYEE INFORMATION			
First Name:		Home Phone () -	
Last Name:		Date of Birth:	
SSN:	Email Address: *Used for notification of payment and receipt of claim.		
Street Address:			City:
State:	Zip:	Effective Date: ____/____/____	First Pay Period: ____/____/____
Pay Frequency: Bi- Weekly		Total # Pay Periods: 24	

PLAN ELECTION DESCRIPTIONS		
Healthcare-Flexible Spending Account (FSA) Out-of-Pocket prescription, medical, dental, and vision expenses. Contribute up to \$2650.00 for the Plan Year. (Min. \$0.00)	<input type="checkbox"/> YES <input type="checkbox"/> NO Rollover dollars only <input type="checkbox"/>	Contribution Amount: \$ _____ Annual Election: \$ _____
Dependent Care Assistance Program (DCAP) Child and/or adult daycare expenses. If married filing jointly or single – Contribute up to \$5000.00 for the Plan Year. If married filing separately – Contribute up to \$2500.00 for the Plan Year.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Contribution Amount: \$ _____ Annual Election: \$ _____
Direct Deposit (If selecting this option – ALL Bank Information Below is REQUIRED) Used for paper claims sent to Benefit Advantage for reimbursement directly to your bank account. I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of \$10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the \$10.00 fee. Bank NINE digit routing number (Include zeros where present) _____ Bank Account Number: _____ Bank Name: _____	Select One: <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Cancel/ Stop <input type="checkbox"/> Continue	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
<input checked="" type="checkbox"/> Yes, Please send me a DEBIT card to use for my Healthcare Reimbursement Account		

EMPLOYEE AUTHORIZATION	
I understand that the choices I have indicated above must remain in effect for the entire plan year unless I have a change in family status. A change in family status includes the birth or adoption of a child, marriage, divorce, death, spouse losing or gaining a job, or a change in employment status from part-time to full-time or full-time to part-time. I hereby authorize my employer to deduct from my salary the required contributions for the amounts I have elected.	
Signature:	Date

See additional information on the back of the enrollment form regarding benefits

General Plan Information

- ✓ City Of Green Bay's Plan Year renews every **January** and runs for 12 consecutive months.
- ✓ Annual Health Care Account maximum is \$2650.00.
- ✓ Annual Health Care Account minimum is \$0.00.
- ✓ Annual Dependent Care Account maximum is \$5000.00.
- ✓ Annual Dependent Care Account minimum is \$0.00.
- ✓ After the plan year-ends, you have **90 Days** to submit expenses incurred during that plan year.
- ✓ If your employment terminates during the plan year, you will have **90 Days** to submit expenses incurred up to your termination date.
- ✓ The Health FSA "Rollover" amount is **\$500.00**. The Rollover allows you to rollover unused funds up to **\$500** from the Health FSA at the end of the plan year to the subsequent plan year. Any unused funds over the allowable **\$500** will be forfeited. The Rollover dollars may be used to pay or reimburse medical expenses under the Health FSA incurred during the entire subsequent plan year.
- ✓ Your election will remain in effect for the entire plan year, unless you have a qualifying status change and the change is consistent with the qualifying event.

Healthcare-Flexible Spending Account (FSA)

The Health Flexible Spending Account (FSA) gives you the benefit of allocating money pre-tax for reimbursement of out-of-pocket medical expenses incurred by you and your dependents during a Plan year. Dependents include your spouse, children residing with you, or a parent for whom you claim on your taxes as a dependent. *You do not need to participate in your Company's group insurance plan in order to participate in the Health Care Flexible Spending Account.*

Eligible expenses include, but are not limited to, prescriptions, your medical and dental deductibles, co-pays, vision and hearing care, expenses in excess of "usual, reasonable and customary" charges and other health care costs not covered under your or your spouse's insurance plan.

Benny Card

The Benny Card is a pre-paid benefit card that allows you direct access to the funds in your Health FSA without sending in a request for reimbursement and paying out of pocket.

Substantiation for card swipes will be requested in the event the card cannot determine the type of expense being requested at the point of sale.

Dependent Care Assistance Program- (DCAP)

The IRS states that an eligible dependent for the purpose of a Dependent Care reimbursement Plan is a child under 13 years old and living with you. An eligible dependent, regardless of age, may also include your mentally or physically impaired spouse/dependent/child that is living with you regardless of age and incapable of caring for themselves.

To be eligible to participate in this account all of the following must apply:

1. The expenses must be necessary to allow you and your spouse to work, seek employment, or attend school full time.
2. Providers **must** declare the funds you pay them as income on their tax returns.

 The IRS states the annual maximum amount a family may withhold in a dependent care plan is the lesser of \$5,000 per family, or you or your spouse's income. A single parent is eligible for this program with the above limitations.

If you and your working spouse have dependent care accounts with your employers, the combined contribution may be no greater than \$5,000. Married individuals filing separate tax returns can each claim a maximum of \$2,500 through a dependent care account.

If you are married and your spouse is a full-time student or unable to care for himself, or herself, you may claim \$2,400 if you have one (1) dependent, or \$4,800 if you have more than one dependent.