



Employee Reimbursement Accounts Enrollment Form

Make sure to sign, date, and complete each line on the enrollment form. Please enter zero (0) where no amount is being deducted. **Return the completed and signed form to your employer.** For enrollment assistance, call toll-free 844-786-3947. Have your enrollment form ready. **Please Print and save a copy for your records.**

Please indicate employee's current payroll center: ___ Courts ___ Legislature ___ UW Hospitals & Clinics ___ UW
 ___ Central ___ WHEDA ___ WEDC ___ Wiscraft Beyond Vision

Employer Name _____

Participant Last Name _____ First Name _____ Middle Initial _____

Participant's Date of Birth _____ Participant Date of Hire _____

Participant Email Address* _____

Participant Home Phone Number* _____ Participant Mobile Phone Number* _____

Participant Street Address _____

City _____ State _____ Zip _____

Participant's Plan Effective Date _____ Date of First Payroll _____

*Required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

Election Amounts

Prior to completing your election amounts, refer to the instructions and frequently asked questions on page 2.

	# of Payroll Deductions	Employee Annual Salary Reduction Election	2016 Annual Maximum
I request the following amount(s) to be deducted pre-tax:			
1. Health Care Flexible Spending Account (FSA)	_____	\$ _____	\$ 2,550
2. Limited Purpose Health Care FSA	_____	\$ _____	\$ 2,550
3. Dependent Day Care FSA	_____	\$ _____	\$ 5,000
4. Transit Expenses	_____	\$ _____	\$ 1560
5. Parking Expenses	_____	\$ _____	\$ 3000

TASC Card

Additional TASC Card for Spouse or Dependent

Each Participant may receive one additional card for their spouse or dependent free of charge. To request an additional TASC Card for your spouse or dependent, print his/her name below. Cards are mailed to your home address in December or 7-10 days after your enrollment has been updated.

Spouse or Dependent Name (Last, First, MI): _____

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire Plan Year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s). I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature _____ Date _____

Enrollment Form Instructions

- 1. Health Care FSA Expenses:** This amount is usually paid per year toward deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eye care, and other miscellaneous healthcare expenses. Per IRS regulations, a Participant may salary reduce the maximum of \$2,550 (2016) per Plan Year (indexed annually for inflation).
- 2. Limited Purpose Health Care FSA Expenses:** If also enrolled in a Health Savings Account (HSA) you may participate in a Limited Purpose Health Care FSA plan that allows reimbursement for dental, vision, and post-deductible expenses only.
- 3. Dependent Day Care FSA:** Amount paid for day care expenses per year. The maximum allowable amount under IRS regulations is \$5,000 per calendar year per family; \$2,500 per calendar year for married individuals filing single.
- 4. Transit Expenses:** Amount incurred to travel to and from work on mass transit facilities or commuter highway vehicles. Examples of eligible expenses are vouchers, farecards, or tokens for a bus, train, ferry, subway, or vanpool. Monthly limits apply.
- 5. Parking Expenses:** Eligible amounts include parking at or near your place of employment or at a location from which you commute to work (e.g. ramp or park 'n ride). Monthly limits apply.

Frequently Asked Questions

- 1. What does FlexSystem offer?** FlexSystem offers you a choice to pay for certain qualified benefits on a pre-tax basis. Paying for certain benefits with pre-tax dollars reduces the amount you pay in taxes and increases your take-home pay. Every dollar paid on a pre-tax basis results in a savings to you.
- 2. Any cost or fee to me?** No.
- 3. Must I participate in my employer's health insurance?** FlexSystem is not tied to any insurance plan or company. You may participate in FlexSystem regardless of your particular insurance provider.
- 4. What are qualified medical expenses?** These expenses include dental care, prescriptions, eyeglasses, and out-of-pocket medical expenses not covered by insurance. However, vitamins and other dietary supplements taken for general health purposes are not eligible. Purchases of over-the-counter (OTC) medicines and drugs (with the exception of insulin) are only reimbursable if accompanied by a prescription or Prescription Order Form from your medical practitioner. Participants in the Limited FSA can expense dental, vision and post-deductible expenses. Below are some *examples* of eligible OTC health related expenses:
Examples of OTC items that require a prescription or Prescription Order Form: Acid Controllers, Allergy and Sinus, Antibiotic Products, Cough, Cold and Flu, Digestive Aids, Pain Relief, Respiratory Treatments, Sedatives, and Stomach Remedies.
Examples of OTC items that are eligible and need no physician authorization: Bandages, Blood Pressure Kits, Contact Lenses, Contact Lens Solution, Diabetes Testing Supplies, Durable Medical Equipment, Hearing Aid Batteries, Heating Pads, Insulin, Nebulizers, Thermometers, and Walkers and Wheelchairs.
- 5. How does the Dependent Day Care FSA compare with the tax credit available on the individual Form 1040?** The circumstances that determine which option offers greater savings vary from family to family, as such, the decision to choose the tax credit or the dependent care deduction may be made on a case by case basis only. Participation in FlexSystem results in an immediate savings on Federal, State, and Social Security tax, whereas the Federal credit will affect Federal Income Tax only and will be taken at year-end.
- 6. How does a Cafeteria Plan affect Social Security benefits?** Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower health care costs available under FlexSystem. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.
- 7. Under what circumstances can the annual election be changed?** The elections may be changed only if there is a change in family or employment status. See the Change of Elections Form for more detail.
- 8. Carryover for Health Care FSA and Limited Purpose Health Care FSA?** Your employer offers the Carryover Provision which allows up to \$500 of your account balance to automatically carry over into the next plan year once the run-out period has ended. Any remaining funds over \$500 at the end of the plan year run-out period will be forfeited to your employer.
- 9. Who determines the rules and regulations of FlexSystem?** Flexible Spending Accounts are regulated by the IRS. Our documentation guidelines are intended as a means to ensure eligibility of your requests for reimbursement. It is the Participant's responsibility to comply with these guidelines and to avoid duplication of requests or submission of ineligible charges. Failure to adhere to the above requirements could lead to payment delays or denial of expenses. In the event of an error or omission in the course of administering the Plan on behalf of the employer and participating employees, TASC will notify and remedy the error or omission. The employer and employees agree to TASC's procedures for making any corrections, including but not limited to payroll reduction. An error by the employer or TASC does not constitute an assumption of liability for the amount of the error.

If you are unsure which Payroll Center you are a part of, please contact your HR/Benefits Specialist.