Flexible Spending Accounts
Member Enrollment or Change Request

Instructions for Completing the Request Form

Employer

Complete the **FSA Type** selection(s) based on which Flexible Spending Account(s) (FSA) are offered to employees.

Complete the **Deduction Election(s)** date of first payroll deduction and pay period deduction amount after the employee has returned the completed Request form to you.

Send the completed Request form to MVP at:

MVP Flexible Benefits Department
MVP Health Care
PO Box 2207
Schenectady NY 12301-2207

myspendingaccounts@mvphealthcare.com

Employee

Complete the Request form, and if requesting direct deposit reimbursements, also complete the Direct Deposit Authorization form, and return to your employer's Health Benefits Administrator.

Flexible Spending Accounts

Medical FSA

Medical FSA funds are used for reimbursement of health care expenses not paid from any other source. Contributions to the FSA are pretax dollars.

Limited Purpose FSA

Limited Purpose FSA funds are used for reimbursement of qualified dental and vision expenses not paid from any other source. The Limited Purpose FSA must be paired with a Health Savings Account (HSA). Contributions to the FSA are pretax dollars.

Dependent Care FSA

Dependent Care FSA funds are used for reimbursement of daycare expenses for eligible dependents. For 2021, annual contributions to a Dependent Care FSA are limited to $5,000 for individuals or married couples filing jointly, or $2,500 for a married individual filing separately. Contributions to the FSA are pretax dollars.

Considerations Upon Enrollment

- By enrolling in an FSA, you agree to have your compensation reduced by the amount you elect.
- Your election applies to the current plan year only. **To continue in the Plan, you must re-enroll each year.**
- Annual health care elections (FSA, LPFSA) are available for reimbursement in full on the first day of the plan year.
- Dependent care elections are available for reimbursement based on current balance.
- FSA accounts are tracked separately and cannot be combined. These elections are in addition to any premiums you pay on a pretax basis for employer sponsored health insurance.
- Dependent Care FSA pays for daycare services needed for a qualifying dependent while you work. A qualifying dependent is a child age 12 and under who is claimed as a dependent on your federal income tax return (special rules apply for divorced parents), a disabled spouse, and any other dependent on your tax return who resides in your home and is physically or mentally disabled.
- You may file claims for reimbursement from your FSA account(s) for qualified expenses incurred during the plan year and after becoming a participant. Depending on the provisions in your plan, some or all of the funds remaining in your FSA account after the end of the plan's run-out period may be forfeited.
- You will pay your employer for any tax liability or penalties it incurs if you are reimbursed for an expense that is not a qualified expense, unless you repay the amount or off-set that amount with additional eligible claims within the same plan year.
- You cannot change the amount of your FSA contributions or pretax health insurance premiums, unless you have a qualifying "life changing" event as defined in the plan and satisfy any other conditions for changes contained in the plan and tax law.
- Your FSA contributions will terminate when your employment terminates. You must check with your employer to determine if you can elect to continue your health care contributions on an after-tax basis, as allowed under COBRA.
- Your employer may change the amount of your FSA elections if necessary to satisfy tax law requirements.
- You understand that you must provide acceptable documentation for every claim you submit, including MVP CareFund Debit Card purchases upon request (employer plan provisions determine if employees receive an MVP CareFund Debit Card to make qualified medical expense purchases).
- You will keep copies of all documents submitted to MVP Health Care Flexible Benefits Department for your own personal records; MVP Health Care Flexible Benefits Department is not responsible for retaining copies of your receipts beyond the current plan year.
- FSAs are subject to Federal law which generally supersedes State law.

Flexible Spending Accounts

Member Enrollment or Change Request

To be completed by Employer

Employer Name

Plan Year Effective Date

Employer Authorized Flexible Spending Accounts (FSA) Available *(select all that apply)*

☐ **Medical FSA** ☐ **Limited Purpose FSA** ☐ **Dependent Care FSA**

Is the MVP CareFund Debit Card option included with the Medical FSA and/or Limited Purpose FSA? ☐ **Yes** ☐ **No**

Section 1: Reason for Request

☐ **Regular Annual Election**

☐ **Mid-Year Election/Change in FSA Election** *Effective Date:* *Date of First Payroll Deduction:*

☐ **Change in Family Status** *Date of Event:* *Date of First Payroll Deduction:*

- ☐ Divorce/separation
- ☐ Death of a dependent
- ☐ Change in work hours
- ☐ Marriage
- ☐ Spouse became unemployed
- ☐ Unpaid leave of absence
- ☐ Birth or adoption of a child
- ☐ Other:

Section 2: Subscriber Information *(please print)*

Subscriber Name | Date of Birth | Social Security No. | Employee ID No.

Street Address | City | State | Zip Code

Phone No. | Email

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced

Payroll Cycle

☐ Weekly ☐ Biweekly ☐ Monthly ☐ Bimonthly

Section 3: Spouse/Dependent Information

Spouse Name* | Date of Birth | Social Security No.

Dependent Name ☐ *Issue MVP CareFund Debit Card for this individual** | Date of Birth | Social Security No.

Dependent Name ☐ *Issue MVP CareFund Debit Card for this individual** | Date of Birth | Social Security No.

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Dependent Name ☐ *Issue MVP CareFund Debit Card for this individual** | Date of Birth | Social Security No.

**Spouse will be issued an MVP CareFund Debit Card automatically. Eligible dependents must be age 18 or older to receive an MVP CareFund Debit Card. Debit card availability is determined by your employer. Debit cards are not available for the Dependent Care FSA.*

Employer Name *Subscriber Social Security No.*

Section 4: Deduction Election(s)

Select the FSA(s) below in which you are enrolling. *By completing this Section, you are authorizing your employer to deduct the pretax contribution(s) indicated from your compensation.*	**Annual Pretax Deduction**	*Employer Must Complete this Section*	
		Date of First Payroll Deduction	**Pretax Deduction per Pay Period**
☐ **Medical FSA**	$		$
☐ **Limited Purpose FSA**	$		$
☐ **Dependent Care FSA*** *2021 contributions limited to $5,000 for individuals or married couples filing jointly, or $2,500 for a married individual filing separately.*	$		$

☐ **I would like to receive reimbursements from the FSA(s) through direct deposit to a checking or savings account.**
If you select this option, please complete the *Direct Deposit Authorization* form included with this Request form and return it to MVP with this form.

**Amounts contributed to the Dependent Care Reimbursement Account reduce any available federal Child Care Credit.*

Section 5: Authorization

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, if my employer has included the debit card option, 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. Debit cards will be mailed 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 wish 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*

MVP Select Care, Inc.

Direct Deposit Authorization

for MVP Flexible Spending Accounts & Health Reimbursement Arrangements

Select a Reason for Submitting this Authorization

☐ **New Direct Deposit Authorization**

Provide all of the information requested below to activate your direct deposit plan.
You must attach a **voided check** or **savings account deposit slip** below and sign this form.

☐ **Change to an Existing Direct Deposit Authorization** *Effective Date of Change:* _____

Provide all of the information requested below to make a change to your direct deposit plan.
You must attach a **voided check** or **savings account deposit slip** below and sign this form.

☐ **Cancellation of a Direct Deposit Authorization** *Effective Date of Cancellation:* _____

Complete only Section 1, Member Information.

Section 1: Member Information *(please print)*

Employer

Your MVP Member ID No.

Home Phone No.

Member Name

Social Security No.

Daytime Phone No.

Email

Section 2: Direct Deposit Authorization *(please print)*

Attach voided check for checking account deposits or savings account deposit slip for savings account deposits here. One of these must be included to process your request.

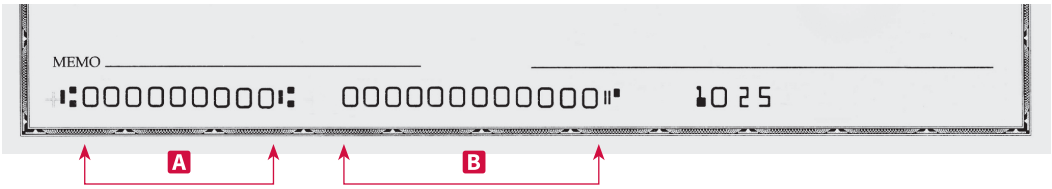
Financial Institution Name

Financial Institution City and State

Account Type
☐ Checking ☐ Savings

A Financial Institution Routing/Transit No.

B Account No. at Financial Institution



Section 5: Authorization

By signing this form, I hereby authorize MVP Select Care, Inc. and its financial institution to initiate credit, and if necessary, debit entries, electronically or otherwise, to my checking or savings account. Debit entries will only be made to correct credit entries made in error. Further, I may be responsible for any bank fees incurred due to incorrect account information or account changes that have not been appropriately communicated to MVP Select Care, Inc. This authority will remain in effect until MVP Select Care, Inc. has received written notification to cancel.

I have read and agree to this authorization.

Account Holder's Name (print) *Account Holder's Signature* *Date*

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