The BESTflex℠ Plan
Employee Benefits Corporation

# Enrollment Form

Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126** | 608 831 8445 | M - F 8:00 - 5:00 Central
E-mail support: **participantservices@ebcflex.com**

■ **Submit completed form to your Employer.**

## General Information

Organization Name

Division

## Participant Information Please print.

Participant Social Security or Identification Number

Last Name

Suffix

First Name

MI

○ M ○ F
Gender

Date of Birth (mm-dd-yyyy)

Date of Hire (mm-dd-yyyy)

Mailing Address

Apt. No.

City

State

Zip Code

Home Phone 123-456-7890

E-mail Address (we do not share your e-mail address)

## Plan Dates (refer to "My Company Plan" Eligibility section)

Effective Start Date (mm-dd-yyyy)

Number of Pay Periods

## Plan Benefits: I elect to have Elections below deducted from my pay tax-free and placed into the following accounts

| | **Employee** Election per Pay Period | **Employee** Election Plan Year Total | **Employer** Contributions (if any) Plan Year Total |
|---|---|---|---|
| Standard Health Care FSA<br>Reimburses all eligible medical expenses; not for use with HSA | $ | $ | $ |
| Dependent Care FSA<br>Reimburses all eligible dependent care expenses | $ | $ | $ |
| Employee Paid Administrative Fees<br>(if any) | $ | $ | $ |
| Total Election Amount | $ | $ | $ |

## Direct Deposit (optional; if you have not done so, **complete banking information below to participate** – authorization is in effect from plan year to the next)

Financial Institution

City

State

Zip Code

○ Checking ○ Savings

Account Number

Routing Number (exactly 9-digits)

## Authorization

○ I enroll in the BESTflex Plan ○ I do not wish to enroll in the BESTflex Plan

I agree this election cannot be revoked or changed during the plan year, unless a qualifying event occurs to justify the revocation or change as authorized by the IRC and Regulations. I understand my Social Security benefits may be affected by my participation in this Plan and that any money I allocate to these accounts and do not spend by the end of the plan year (or grace period, if elected by the plan sponsor) cannot be returned to me (HSA contributions are exempt from this rule). Your annual election will be rounded down if it is not evenly divisible by the number of paychecks. If a debit card has been provided to me, I certify I will only use the Card for payment of eligible expenses under the Plan and any expense paid with the Card will not be reimbursed nor will I seek reimbursement under another Plan. I agree to provide substantiation that any expense is eligible for reimbursement under the Plan, and to reimburse the Plan in cases where I have been reimbursed in error for an expense ineligible under the Plan. I also understand Employee Benefits Corporation may need "protected health information" regarding coverage or benefits to me or my dependents under the Plan. By signing this Enrollment Form, I acknowledge that Employee Benefits Corporation will obtain "protected health information" for purposes of the Plan and only for as long as Employee Benefits Corporation is providing services regarding the Plan. Any information disclosed pursuant to this Enrollment Form will not be subject to redisclosure by the recipient, except for purposes of the Plan. I understand that my enrollment can be denied if I do not sign this form.

If Direct Deposit is elected for reimbursement, I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.

Signature

Date (mm-dd-yyyy)

 

The BESTflex℠ Plan

# Eligible Expenses

## Eligible Health Care FSA Expense Examples:

**Dental Services**
Crowns/Bridges
Dental X-Rays
Dentures
Exams/Teeth Cleanings
Extractions
Fillings
Gum Treatments
Oral Surgery
Orthodontia/Braces

**Insurance-Related Items**
Copays
Coinsurance
Deductibles

**Lab Exams/Tests**
Blood Tests
Cardiographs
Diagnostic Fees
Laboratory Fees
Spinal Fluid Tests
Urine/Stool Analyses
X-Rays

**Medication**
Insulin
Prescribed Birth Control
Prescribed Vitamins*
Prescription Drugs*

**Other Medical Treatments/Procedures**
Acupuncture
Alcoholism *(inpatient treatment)*
Chiropractor Services
Drug Addiction *(inpatient treatment)*
Hearing Exams
Hospital Services
Infertility
In-vitro Fertilization
Norplant Insertion or Removal
Patterning Exercises
Physical Examination *(not employment related)*
Physical Therapy
Speech Therapy
Sterilization
Vaccinations and Immunizations
Vasectomy and Vasectomy Reversals
Well Baby Care

**Other Medical Supplies and Services**
Abdominal/Back Supports
Ambulance Services
Arches
Breast Pumps and Lactation Supplies
Contact Lens Solution and Cleaners
Contraceptives
Counseling *(except for Marriage and Family)*
Crutches
Guide Dog *(for visually/hearing impaired person)*
Hearing Aids & Batteries
Hospital Bed
Insulin Supplies
Learning Disability *(special school/teacher)*
Lead Paint Removal *(if not capital expense and incurred for a child poisoned)*
Mastectomy Bras
Medic Alert Bracelet or Necklace
Medical Miles, Tolls, and Parking
Orthopedic Shoes
Oxygen Equipment
Pregnancy Tests
Pre-natal Vitamins
Prosthesis
Rubbing Alcohol
Splints/Casts
Suntan Lotion/Sunscreen greater than SPF 14
Syringes

 

Transportation Expenses *(essential to medical care)*
Wheelchair
Wigs *(hair loss due to disease)*
■ **Vision Expenses**
Contact Lenses
Contact Lens Solution
Eye Examinations
Eyeglasses
Laser Eye Surgeries
Prescription Sunglasses
Radial Keratotomy/LASIK
Reading Glasses

***This list is not meant to be all inclusive. Other expenses not listed may also qualify. Please refer to Section 213 of the Internal Revenue Code or call our toll-free Participant Services line at 800 346 2126.***

## Eligible with Doctor's Prescription:

**Important note about over-the-counter (OTC) drug reimbursement:** Due to health care reform regulations, the Health Care FSA only reimburses OTC drug expenses if you have and provide a doctor's prescription for them. Doctor's prescriptions must include the patient name, medication name, dosage, time frame for treatment and any other state law requirements. Make sure you plan your annual election accordingly.

Allergy Medicines
Antihistamines
Analgesics
Antacids
Anti-Diarrhea Medications
Anti-Itch Medications
Anti-Nausea Medications
Aspirin
Athletes Foot Creams and Powders
Cold Sore Remedies
Cough Drops
Cough Syrups
Decongestants
Eye Drops
Fever Reducers
First Aid Cream *(Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatments)*
Digestive Tract Relief Medications
Flu and Cold Medications
Hemorrhoidal Medications
Laxatives
Lice and Scabies Treatments
Menstrual Cycle Products *(medication for pain and cramp relief)*
Motion Sickness Pills
Muscle/Joint Pain Relievers
Nasal Sinus Sprays
Nicotine Gum/Patches
Pain Relievers
Pedialyte
Retin A *(non-cosmetic)*
Sinus Medications
Sleeping Aids
Smoking Cessation Products
Sore Throat Sprays
Special Ointments/Burn Ointments
Throat Lozenges
Vapor Rubs
Weight Loss Drugs *(to treat specific disease)**
Yeast Infection Treatments

## *Ineligible* Health Care FSA Expense Examples:

Baby-Sitting
Canceled Appointment Fees
Chapstick/Lip Balm
Contact Lens Insurance
Cosmetics
Cosmetic Surgery/Procedures
Dance/Exercise/Fitness Programs
Diaper Service
Electrolysis
Exercise Equipment
Eyeglass Insurance
Face Cream
Feminine Hygiene Products
Hair Loss Medications
Hair Transplant
Health Club Dues
Illegal Operation or Treatments
Insurance Premiums
Long Term Care Premiums
Marriage or Family Counseling
Massage Therapy*
Maternity Clothes
Mattresses
Meals that are not part of inpatient care
Moisturizers
Nutritional Supplements*
Personal Trainer
Prescription Drug Discount Programs
Prescription Drugs for Hair Loss
Provider Discounts
Rogaine
Shampoos/Soaps
Special Foods*
Suntan Lotion/Sunscreen less than SPF 15
Supplements* *(for general health)*
Teeth Whitening/Bleaching
Toiletries
Toothbrushes *(including battery operated)*
Toothpaste
Vision Discount Program Premiums
Vitamins* *(for general health)*
Weight Loss Programs* *(for general health)*

Employee Benefits Corporation
We make it easy.

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P.O. Box 44347
Madison, WI 53744-4347
An employee-owned company
www.ebcflex.com

*Excludes drugs imported from Canada and other countries. Some medically necessary items may be covered by the Health Care FSA if prescribed by a physician for a specific medical condition. The prescription should contain the specific medical condition and timeframe for treatment.