GROUP INSURANCE COMMISSION

FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

PLAN YEAR: JULY 1, 2016 TO JUNE 30, 2017
2 ½ MONTH GRACE PERIOD: JULY 1 – SEPTEMBER 15, 2017
CLAIM FILING DEADLINE: OCTOBER 15, 2017

Commonwealth of Massachusetts
Group Insurance Commission

A. Employee Information – *Please Print Clearly*

Name: _____ Social Security Number (Required): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Day Phone: _____

Employee ID#-Required _____ Date of Birth: _____

E-mail-Required _____ Agency Name: _____

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Spending Account (HCSA) Eligible health expenses include medical, dental, vision and hearing expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body." See IRS Publication 502 for more information.

$	X		=	$ 0.00
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Election Allowed per Plan Year
$250 minimum/$2,550 maximum

2. Dependent Care Assistance Program (DCAP) Eligible dependent care expenses must be work-related and incurred to allow me and, if applicable, my spouse to be gainfully employed. Qualifying dependents include children under age 13 or older dependents who are not capable of self-care. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes. See IRS Publication 503 for more information.

$	X		=	$ 0.00
Your Contribution Per Pay Period		# of Pay Periods		Total Election

Maximum Election Allowed per Plan Year
$5,000.00
($2,500 if married and filing separately)

C. ASIFlex Card

HCSA participants will automatically receive two debit cards. A $5.00 fee will be assessed annually for additional/replacement card sets and billed directly to your HCSA. Please indicate the number of additional card sets you would like to request below. (You will automatically get 2 cards to start). Please note that cards are ordered in multiples of 2. (Example: 2, 4, 6, 8, etc.)

Additional Card Sets Requested: _____

REQUIRED: You must indicate the medical plan in which you have enrolled. Please check the appropriate box. If not enrolled in a GIC plan, check the last box.

- ☐ Fallon Health Direct Care HMO
- ☐ Fallon Health Select Care HMO
- ☐ Harvard Pilgrim Independence Plan POS
- ☐ Harvard Pilgrim Primary Choice Plan HMO
- ☐ Health New England HMO
- ☐ NHP Care (Neighborhood Health Plan)
- ☐ Tufts Health Plan Navigator POS
- ☐ Tufts Health Plan Spirit EPO (HMO-Type)
- ☐ Unicare State Indemnity Plan Basic with CIC
- ☐ Unicare State Indemnity Plan/Community Choice PPO-Type
- ☐ Unicare State Indemnity Plan/Plus PPO-Type
- ☐ Not enrolled in any plan listed

D. Direct Deposit Authorization

Claim payments can be sent directly to a bank account of your choice, and you can be notified by email/text alert each time a payment is issued.

Bank Name:
(See #1 on sample)

☐ Checking Account
☐ Savings Account

Routing Number – 9 digits (See #2 on sample):

Account Number (See #3 on sample):

_____

Cell Phone: _____ Mobile Carrier: _____

SAMPLE

E. Signatures

By signing below, I agree to the following Terms and Conditions stated on the opposite side of this form.

Employee Signature (required):		Date:	

REQUIRED: The section below must be completed, in full, by agency Payroll/Benefits Coordinator

Benefit Effective Date:	DCAP: _ _ / _ _ /16 HCSA: _ _ / _ _ /16	Qualifying Status Change Date:	_ _ / _ _ / _ _
Agency Coordinator:		Division Code (ex: ABC1234)	_ _ _ / _ _ _ _
E-mail Address:		Phone #:	
Reason for Enrollment:	☐ Open Enrollment ☐ New Hire ☐ Qualifying Status Change		

EMPLOYEES: Please return this form to your Payroll/Benefits Coordinator once complete.
COORDINATORS: Upload to portal or fax completed form to ASIFlex at 877-879-9038 (toll-free), not the GIC.

Revised 3/2016

Enrollment Form Instructions

Section A	**Employee Information** - Please print your name and complete address clearly. Your phone number and e-mail address will be used only to communicate with you with regard to this plan. It will not be distributed to any other organization or used for marketing purposes in any way. Statements of your account balance and activity will be sent via e-mail/text alert whenever possible. Please understand that this is an employee account and due to federal and state laws we cannot release detailed information to anyone other than the participant (employee). Please contact our office for further information or you can sign a HIPAA release to allow others to act on your behalf and obtain information.
Section B	**Flexible Benefit Pre-Tax Elections -** 1. Health Care Spending Account (HCSA) - Carefully consider how much money you would like to set aside each pay period during the Plan Year to pay for your family's eligible out-of-pocket medical expenses. Make sure you read your Participant Handbook to fully understand how the plan works. 2. Dependent Care Assistance Program (DCAP) – Carefully consider how much money you would like to set aside each pay period during the Plan Year to cover the expenses you will incur to care for your eligible dependents while you and your spouse (if applicable) are gainfully employed. Qualifying dependents are children under age 13 or older dependents not capable of self-care. Make sure you read your Participant Handbook to fully understand how the plan works.
Section C	**ASIFlex Card -** You may order an additional set of cards for other eligible dependents if desired. A fee of $5.00 per additional set will be assessed to your HCSA for each set of cards.
Section D	**Direct Deposit Authorization** - If you would like your reimbursements sent directly to your checking or savings account via Direct Deposit, fill out this section and attach a voided check (for checking) or deposit slip (for savings). Confirmations are sent via email/text alert and will show current transaction information, as well as, available funds in the account.
Section E	**Signatures** - After you have completely filled out this form and carefully read the following Terms and Conditions please sign and date then return the enrollment form to your payroll office as applicable. Employers must review the elections and sign that the employee meets the eligibility requirements.

Flexible Benefit Plan Terms and Conditions

I UNDERSTAND THAT:

- By participating in the Flexible Benefit Plan, my employer will deduct pre-tax from my pay check: $2.50 per month for the first paycheck of each month.
- I cannot change this election during the Plan Year unless I have a qualifying change in status as described in the Plan.
- I must make all of my elections carefully and conservatively. Expenses paid under the HCSA or DCAP cannot be reimbursed from any other source and that I will not seek reimbursement from any other source.
- Expenses must be incurred during the Plan Year or the Grace Period. The Grace Period is a 2 ½ month period following the end of the Plan Year during which I may continue to incur expenses for the prior plan year. (September 15, 2017)
- All FY17 plan year claims must be submitted by the claim filing deadline, called a run-out period, which ends October 15, 2017.
- Qualifying expenses are those incurred by me, or by my legal dependents.
- HCSA expenses can be reimbursed up to the plan year election, less prior reimbursements. DCAP expenses can be reimbursed up to the year-to-date deposits, less prior reimbursements.
- The ASIFlex Card can be used only for qualifying health care expenses as defined by IRS guidelines. The IRS requires me to keep documentation of all my card transaction expenses and submit documentation to the administration upon request. If I do not provide the requested documentation as required, IRS regulations require that the card be temporarily deactivated. Claims submitted will be offset by any outstanding card transaction amount. Misuse of the card may result in permanent revocation and repayment of ineligible expenses.

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www.asiflex.com/GIC

IMPORTANT INFORMATION REGARDING ENROLLMENT AND CHANGES

ADMINISTRATIVE FEE

The cost to administer this program is paid for by each employee on a before tax basis. The monthly administrative fee is $2.50 for any account participation – for Health Care Flexible Spending Account (HCSA) alone, Dependent Care (DCAP) alone or for HCSA/DCAP combined.

ELIGIBILITY AND ANNUAL MAXIMUM AND MINIMUM FOR HCSA AND DCAP

HCSA: Active state employees who are eligible for GIC benefits. The waiting period is the same as for other GIC life and health benefits. Minimum $250; Maximum $2,550.

DCAP: Active state employees and contract employees who work at least 18.75 hours per 37.5 hour work week or 20 hours per 40 hour work week. You are eligible on the first day of employment. Enrollment forms must be submitted to your Payroll Coordinator within 30 days from your date of hire. Maximum $5,000. ($2,500 if married and filing separately)

CHANGE IN STATUS

Elections may be changed during open enrollment. You may only change your election mid plan year if you experience a "change in status" as defined in the Plan. Only the following events will be considered a valid change in status under Internal Revenue Service rules.

- Change in legal marital status
- Change in number of dependents
- Change in employment status that changes your eligibility for the program
- Change in work schedule, which changes your eligibility for the program
- Dependent satisfies or ceases to satisfy eligibility requirements
- Judgment decree or order pertaining to child or spouse

If you would like to terminate your elections as a result of a valid change in status, enter a zero dollar amount in the HCSA/DCAP section(s) of the enrollment form. Payroll Coordinators must obtain the appropriate supporting documentation of a Change in Status, such as a copy of the marriage or birth certificate. Please see the current plan year Participant Handbook for additional information and information regarding Leaves of Absence and Leaving State Service. Forms must be submitted within 30 days of the qualifying event.

SIGNATURE AND FORM SUBMISSION

The employee and Payroll/Benefits Coordinator must sign this form. All forms must be submitted to the Payroll Office at your work site. The Coordinator must send the original form to ASIFlex. Please do not send completed forms to the GIC.

ELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN

Eligible expenses under a Dependent Care Assistance Plan are defined as those that are "work-related" as defined in the regulations and enable the participant and the participant's spouse to work or to look for work, and are incurred for the protection and well-being of the dependent. Dependents must be under the age of 13 or, if older, not capable of self-care. Qualifying providers and expenses include:

- Child Care centers that care for six or more children and that meet the IRS' definition of a qualified day care center.
- Caregivers for a disabled spouse or dependent who lives with the participant and is not capable of self-care.
- Babysitters for work-related expenses
- Before school or after school care
- Day Camp (not overnight camps)
- Household expenses provided that a portion of such expenses are incurred to ensure a qualifying dependent's well-being and protection.

Note: Please see IRS Publication 503 additional information. In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19. IRS calendar year pre-tax maximum is $5,000.

INELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN

- Expenses for services not yet provided, even if you must pay in advance
- Babysitting for social events, or services that are not "work-related" as defined by the IRS
- Educational or tuition expenses (kindergarten, first-grade or higher)
- Overnight camp, summer school, lessons (dancing, musical, etc.)
- Expenses incurred while you are not working or looking for work
- Note: If you are divorced, only expenses incurred by the custodial parent may be considered

ELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT

Eligible expenses under a HCSA are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program. Eligible expenses are listed in the Participant Handbook available on the GIC's web site, www.mass.gov/gic/fsa. Don't forget that expenses such as insurance premiums may be deductible on Schedule A tax return, but not eligible for reimbursement through a HCSA. Some examples of eligible expenses are: acupuncture, ambulance, artificial limbs, contact lenses, health plan deductibles, dental expenses, health and RX co-pays, hearing aids, vision expenses, over-the-counter health care products, and more. Additional information is also located at www.asiflex.com/gic

INELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT

- Expenses for services not yet provided, even if you must pay in advance
- Expenses paid under any other source (such as another insurance plan)
- Cosmetic treatments, medications or surgery (such as teeth whitening, face lifts, hair transplants, etc.)
- Expenses for general health and well-being (such as fitness programs, exercise equipment, health club memberships, etc.)
- Insurance premiums
- Expenses that are not properly substantiated.