Flexible Spending Account

Enrollment Information

Sign Up and Save Dollars!

Flexible Spending Account Plan: Why It Saves Dollars

The Flexible Spending Account allows participating employee out-of-pocket expenditures on uncovered medical, dental, vision, and other medical related service to be paid with tax-free dollars. Employees participating in the medical plan can elect to direct a portion of their salary to the flexible spending account. The employee's redirected salary is "banked" by the employer in an account maintained for the employee. When an expense is incurred for a covered service (i.e., medical expenses not covered by insurance because of paying deductible, coinsurance or some other uncovered expense), the employee is reimbursed from the dollars in the "banked" account.

The dollars redirected into the plan escape federal, state and social security taxation. This can amount to a savings of 33% to 40%, depending upon the employees tax bracket. An example follows:

	Without FSA:	With FSA:	
Annual Salary	$24,000	$24,000	
Salary Diversion	$ 0	$ 1,000	
Taxable Salary	$24,000	$23,000	
Tax Estimate:			
Federal @ 22%	$ 5,280	$ 5,060	
State @ 4.5%	$ 1,080	$ 1,035	
FICA @ 7.65%	$ 1,836	$ 1,760	
After Tax Salary	$15,804	$15,145	
Medical Expenses	$ 1,000	$ 1,000	
FSA Account Payment	$ 0	$ 1,000	
Spendable Income	$14,804	$15,145	+$341 Saved

*Your savings will vary based on salary / tax bracket and amount diverted.

Frequently Asked Questions

Is it possible for the employee to forfeit or lose a contribution?

Contributions are lost only when an employee's actual expenses do not equal the contribution put into the plan. To avoid this possibility, it is recommended that employees carefully plan their contributions. A planning form is included with this package.

Can employees change or revoke the contribution during the year?

Generally speaking, the contribution level is decided for an annual period and cannot be changed. The only exception is a change in family status including divorce, marriage, death of a spouse or child, birth or adoption of a child or other significant lifetime event.

Who should participate in the FSA?

Any employee in the who is fairly certain to spend money on medical, dental or vision related costs should use the budget sheet to estimate their out-of-pocket expenses from the date the employee becomes eligible to the next December 31 and designate that amount to be diverted to the "bank" account.

How do employees sign up for the plan?

Employees eligible to participate in the Medical Plan should complete and return the "Flexible Spending Account Election" form. The amount of salary diverted and the corresponding tax reduction will be deducted from the payroll month in which medical coverage begins. When covered medical, dental or vision expenses are incurred, participants can use their debit card or file for reimbursement and will be reimbursed for covered services up to the level of the amount diverted.

When Will Your Plan Begin?

Once you are eligible to participate in the medical plan and enroll in the Flexible Spending Account Plan, your tax savings will begin.

Medical Care Reimbursement Account

THIS FORM IS PROVIDED AS A PLANNING TOOL. THERE IS NO NEED TO RETURN IT.

ıis worksheet will help you estimate your annual costs. This list is intended to be used as a guide. Please review the formation provided below before completing. List all costs not reimbursed by insurance incurred by you, your ouse and dependents. To be reimbursed, the services must be prescribed by a physician to treat a medical condition.

QUALIFYING EXPENSE	ESTIMATED ANNUAL EXPENSE
Medical Plan deductibles, coinsurance, copays	$____________________________
Laser Eye Surgery	____________________________
Annual physical examinations	____________________________
Dental examinations and treatment	____________________________
Eye examinations, Eye Glasses, Contacts	____________________________
Prescription drugs/copays	____________________________
Over the counter goods and drugs	____________________________
Hearing aids	____________________________
Chiropractors services	____________________________
Non-Cosmetic surgery	____________________________
Ambulance service	____________________________
Nursing home costs	____________________________
False teeth	____________________________
Mental and nervous services	____________________________
Acupuncturists	____________________________
Orthodontia	____________________________
Smoking Cessation Program	____________________________
Weight loss program	____________________________
Other allowed services not listed above	____________________________
(A) Total Annual Unreimbursed Medical Expenses	____________________________
(B) Number of Pay Periods Remaining	____________________________
(C) Amount of Redirection per Pay Period (A / B)	____________________________

FSA Qualifying Medical Care Expenses

Under the Plan, you will be reimbursed only for those medical expenses generally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation). They include the services listed below **when they are recommended by a physician to solve a medical problem**:

1. Medicine, drugs, vaccines and vitamins prescribed by your doctor.
2. Medical care by licensed providers of care including MD's, dentists, chiropractors, osteopaths, psychiatrists, podiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts. Dental care provided by a licensed dentist and vision care provided by a licensed vision provider..
3. Medical examinations, x-rays and lab services, insulin treatment prescribed by a doctor.
4. Nursing help in your home or elsewhere.
5. Hospital care (including meals and lodging), clinic costs and lab fees.
6. Medical treatment at a center for drug addicts or alcoholics.
7. Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
8. Ambulance services and other travel costs to obtain medical care. If you use your own car, you can claim the cost of gas to and from the place of treatment or you can claim costs on a cents per mile basis. See IRS publications for the current cents per mile reimbursement. Parking and tolls are also covered.
9. Qualifying medical expenses for yourself, spouse and dependents listed on your federal return and any person that you could have listed on your federal return if that person had received $2,000 or less of gross income or had not filed a joint return.
10. Smoking cessation programs to help you stop smoking.
11. Weight loss programs when treating a medical condition.
12. Laser surgery to correct eyesight problems.

You cannot obtain reimbursement for: premiums incurred by your spouse for accident or health insurance, the basic cost of Medicare Insurance, life insurance or income protection policies, the hospital insurance benefits tax withheld from your pay as part of Social Security tax, nursing care for a healthy baby, illegal activities and travel prescribed by your doctor for the purpose of rest or change.

Note: See IRS Publication 502 at www.IRS.gov for a more detailed explanation.

Dependent Care Assistance Reimbursement Account

THIS FORM IS PROVIDED AS A PLANNING TOOL. THERE IS NO NEED TO RETURN IT.

This worksheet will help you estimate your annual dependent care assistance costs. This list is not intended to be comprehensive but may be used as a guide. Review the information provided below, "Qualifying Dependent Care Expenses", to identify if you may be eligible for additional categories of dependent care assistance and to assure you account for any maximum limits before completing.

QUALIFYING EXPENSE	***EST. MONTHLY COST***
Amounts paid to dependent care center (e.g. child care)	$______________________
Amounts paid for dependent care services outside your home	$______________________
Amounts paid for dependent care services in your home	$______________________
Calculation	
(A) Total Monthly Dependent Care Expenses	$______________________
(B) Number of Months Remaining	______________________
(C) Amount of Redirection Annually (A x B)	$______________________
(D) Number of Pay Periods Remaining	______________________
(E) Amount of Redirection per Pay Period (C / D)	$______________________

Qualifying Dependent Care Expenses

Under the Plan, you will be reimbursed only for dependent care expenses meeting all of the following conditions:

1. The reimbursement (when aggregated with all other reimbursements received by you under the dependent care assistance Plan during the same year) may not exceed the least of the following:
   a. $5,000 if single or married filing a joint return, and $2,500 if married and filing separate returns;
   b. Your taxable compensation; or
   c. If you are married, your spouse's actual or deemed income. Your spouse will have deemed income of $200 ($400 if two or more dependents) per month when physically or mentally incapable of caring for him or herself or when a full time student.
2. Dependents must be under age 13 and declared a dependent on your federal taxes or must be a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. Expenses must be for the portion of the Plan year remaining after the effective date of the election.
4. Expenses must be incurred to enable you to be gainfully employed.
5. If the expenses are incurred for services outside your household, they are incurred for an eligible dependent who regularly spends 8 hours in your household.
6. If services are provided by a dependent care center, the center complies with all applicable state and local laws and regulations. This is a facility that provides care for more than 6 individuals not residing in the facility.
7. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which paid.
8. The expenses are not paid to an individual for whom you or your spouse is entitled to a personal exemption as a dependent.

NOTE: Dependent care expenses reimbursed through this Plan must be used to offset the child care credit under the Family Support Act. If you are not eligible by IRS guidelines for the child care credit, you are not considered eligible for this Plan.

Flexible Benefit Plan Election Form

Plan Year From: __ / __ / __ To __ / __ / __

Employer Name: ______________________________

Employee Name: ______________________________

Employee Address (Street & Number): ______________________________

City: ____________________ State: __________ Zip: __________

Employee Social Number: ___ __ ____ Date of Hire: __ / __ / __

Employee Date of Birth: __ / __ / __ Employee E-Mail Address: ____________________

Names Of Dependents:	Date of Birth	Names Of Dependents:	Date of Birth
1) ____________________	__ / __ / __	4) ____________________	__ / __ / __
2) ____________________	__ / __ / __	5) ____________________	__ / __ / __
3) ____________________	__ / __ / __	6) ____________________	__ / __ / __

Election Statement: I hereby elect to participate in my Employer's Benefit Plan for benefits made available under the Flexible Spending Account (internal revenue code sections 79, 105, 106, 125, 129) as amended from time to time. As a participant in the Plan, I understand that I may redirect a portion of my pay (or make contributions directly if deductions from my paycheck cannot be made) to provide benefits under the Plan and that all such benefits will be paid with pretax dollars. I also understand that it is an irrevocable election for the plan year unless I have a qualified family status change and that I am at risk of losing benefits if I do not spend the total amount of my election during the Plan Year.

My employer is hereby authorized to redirect my compensation in the amounts indicated below to provide for my benefit selections under the Medical Reimbursement Account and/or the Dependent Care Reimbursement Account. The amount redirected per pay period will be the amount I redirect for the year divided by the number of pay periods.

Medical Reimbursement Account
(limited to amount stated in the Plan) $ ____________ Per Plan Year

Dependent Care Reimbursement Account $ ____________ Per Plan Year
(cannot annually exceed $2,500 for married filing separately or $5,000 for single, or married filing jointly)

I understand that I will receive eligible reimbursement from the Reimbursement Accounts when I provide my Employer or Claims Administrator with the required information. I also understand that I can change my elections each year during the election period, and if I do not make a change at that time, my election will remain the same for the new Plan Year. If I terminate employment, I understand that the Plan Document will control any continued participation under the Plan. I understand that by participating in the Plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed.

Beneficiary Designation: In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek payment from the plan. I therefore designate the following beneficiary:

Name: ____________________ Date of Birth: __ / __ / __ Relationship: __________

I have made no election for and therefore decline participation in the following checked Flexible Benefit Plan Programs:

☐ Medical Reimbursement Account ☐ Dependent Care Reimbursement Account

As an eligible employee, I hereby select the above choices, including any enrollment or decline choices selected.

Employee Signature: ______________________________ **Date:** __ / __ / __

Avalon Benefit Services, Inc. P.O. Box 1803 Dublin OH 43017
Ph. 614-764-4516 Fax. 614-793-9733 Staff@AvalonBenefits.com

Direct Deposit Information

The picture immediately below displays the information we need to setup direct deposit to your bank account. This will speed the payment to you and eliminate the need for you to go to a bank to deposit a check payment. Please complete the form at the bottom of the page so we can establish a direct deposit to your bank for payments due to you.

Bank Found - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Address http://eflex.com/demo/participantPortal/ Go Links

Routing Number:* 11000015 Change your Bank
Account Number:*
Account Type:* Checking
Bank Name:* SAMPLE BANK
Account Nickname:*
Address Line 1:* 1000 PEACHTREE STREET NE
City:* HOMETOWN CITY
State:* Georgia
Zip Code:* 30309-4470

Joan E. Hancock
75012 Colson Avenue
Louisville, Kentucky 40225
1000
AnyBank USA
Anywhere, USA
routing and transit #
checking account #
check #

* = required field

Continue

Done Internet
Start 8:26 AM

Please complete the following information for direct deposit setup:

Bank Name: ______________________________

Bank Routing/Transit Number: ______________________________

Bank Address Line 1: ______________________________

Bank Address City: ______________________________

Bank Address State: ____________ Bank Address Zip: ____________

Bank Account Number: ______________________________

Account Type (checking/savings): ______________________________

Bank Account Nickname: ______________________________

IMPORTANT: PLEASE INCLUDE A COPY OF A VOIDED BLANK CHECK WITH THIS FORM