UNION HOSPITAL

2017 HEALTH CARE FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Employee Name_____ ID#_____

$2600 Maximum

I hereby authorize Union Hospital to reduce my earnings for the 2017 plan year by $_____ per pay (x 24 pays) for a total of $_____ for deposit into my Health Care Flexible Spending Account to make this money available to me for reimbursement of out-of-pocket expense.

I understand that I will forfeit any unused balance in my account at the end of the plan year and/or 2 ½ month grace period. I also understand that I cannot change my plan participation unless I have a change in status, as defined by the Internal Revenue Service Code Section 125.

Signature_____Date_____

Other Coverage Information

Your flexible spending account cannot consider out-of-pocket expenses until all other health insurance has been considered. Please complete the following by circling the appropriate choice:

Are you covered under another group health plan? **YES NO**

If yes, type of coverage: (circle each that applies) **MEDICAL DENTAL VISION RX**

Name of Carrier_____
Are you enrolled in Medicare Part D? **YES NO** Effective Date_____

Are you enrolled in a High Deductible Health Plan? **YES NO** Effective Date_____

If yes, do you have an HSA with your high deductible health plan? **YES NO**

Are your children covered under another group health plan? **YES NO**

If yes, type of coverage: (circle each that applies) MEDICAL **DENTAL VISION RX**

Is your plan primary or secondary? **PRIMARY SECONDARY**

Name of Carrier_____
Are your children enrolled in Medicare Part D? **YES NO** Effective date_____

Is your spouse covered under another group health plan? **YES NO**
If yes, type of coverage: (circle each that applies) **MEDICAL DENTAL VISION RX**

Name of Carrier_____

If your spouse has Medicare, is he/she enrolled in Part D? **YES NO** Effective Date_____
Is your spouse enrolled in an HSA? **YES NO** Effective Date_____

Are you and/or your dependents covered under an HRA (Health Reimbursement Account) YES___NO___

****Please be advised you must exhaust your HRA account prior to consideration by your Flexible Spending Account. ****
****If you participate in an HSA certain expenses may not be eligible under your FSA. Please contact your tax advisor.****

Note: Salary reductions are credited to your account on a per paycheck basis.
Your salary reduction is made on a pre-tax basis, in accordance with the IRS Section 125 Guidelines.