FLEXCHOICE

Healthcare and Dependent Care Flexible Spending Account Enrollment / Change Form

Sentinel Benefits & FINANCIAL GROUP
Custom Solutions for Life and Wealth

INSTRUCTIONS

Participant:
1. Provide the information requested below. Please print.
2. Sign and date form.
3. Submit to Human Resources for a signature (required).

HR:
1. Complete the Employer Verification section.
2. Mail or fax to Sentinel Benefits. Fax: 781-213-7301

EMPLOYER NAME

City of Gloucester

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
DATE OF BIRTH	**WORK PHONE**		**HOME PHONE**
DATE OF HIRE	☐ SINGLE ☐ MARRIED	**PAYROLL MODE**	☐ WEEKLY ☐ SEMI-MONTHLY
EMAIL ADDRESS	☐ OFFICE ☐ HOME		☒ BI-WEEKLY ☐ MONTHLY

HEALTHCARE SPENDING ACCOUNT

☐ YES, I choose to participate in the FlexChoice Health Care Spending Account. I authorize my employer to deduct the following amount:
$_____ per pay period for 26 (number of) pay periods for an annual amount of $ _____.

DEPENDENT CARE SPENDING ACCOUNT

☐ YES, I choose to participate in the FlexChoice Dependent Care Spending Account. I authorize my employer to deduct the following amount.
$ _____ per pay period for _____ (number of) pay periods for an annual amount of $ _____ .

If enrolling during the plan year, be sure to calculate your annual election based on the remaining pay periods in the plan year.

DEBIT CARD

Debit Cards come in sets of two (2)*	Number of Sets	Annual Fee
Employee Debit Card	1	N/A
Dependent Debit Cards		$5.00

*You will automatically receive two (2) Employee Debit Cards at no cost to you. To order an additional set of cards for dependents, please indicate in the box provided.

*Your cards are valid for three years. Hold on to your cards through the expiration date, even if you do not participate in all three years.

DIRECT DEPOSIT

☐ YES, I choose to receive or continue to receive my FlexChoice reimbursement via Direct Deposit. I authorize Sentinel to make deposits as indicated below.

Bank Name: _____ Account #: _____

Bank Routing #: _____ ☐ Checking **(COPY OF VOIDED CHECK REQUIRED)** ☐ Savings

(Routing number must be 9 digits. Contact your bank to verify.)

☐ NO, I do not wish to receive reimbursement via Direct Deposit. I choose reimbursement via check payment.

AUTHORIZATION TO PARTICIPATE

I understand that I may not increase or decrease the amount of my income reduction until the next plan Year, except to reflect a change in my family status (e.g. marriage, birth of a child, divorce or death). In making contributions to the spending accounts, I understand that I may forfeit any amounts in my account if I do not incur eligible expenses by the end of the plan Year. In addition, I understand that my Social Security benefits may be slightly reduced because I will pay less Social Security taxes. This election replaces any previous elections and will terminate on the earlier of (1) the end of the plan Year; (2) when I am no longer being compensated in an amount at least equal to my total salary reduction; (3) termination of the plan. My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I certify that: (i) I understand that pre-tax funds deposited into my FlexChoice account via payroll deductions as authorized by me upon enrollment in the FlexChoice program, (ii) I will only use the debit card to pay for any and all qualified expenses as defined under Sections 105, 125, 129, 132, and 213 of the Internal Revenue Code and as permitted by my Employer's plan, (iii) I understand that qualified expenses will be deducted directly from my FlexChoice account and that any non-qualified expenses or qualified purchases that exceed the available funds in my FlexChoice account may be declined by the merchant, (iv) I will only use the debit card for qualified expenses which have not been and will not be reimbursed under any other plan (v) I understand that if my Employer later identifies a reimbursed claim as a non-qualified expense, I will be responsible to repay the amount. my Employer may withhold the amount from my wages, my Employer may offset amounts reimbursed for non-qualified expenses against future claims for reimbursement, or my Employer may deny access to the debit card until the amount is repaid, (vi) I will retain receipts and other documentation for the expenses paid with the debit card. If the debit card fee is paid for by the employee, Sentinel will automatically deduct the annual fee from your FlexChoice Account when your enrollment form is processed.

SIGNATURE _____ DATE _____

EMPLOYER VERIFICATION (TO BE COMPLETED BY HUMAN RESOURCES)

Qualifying Event Date _____ Qualifying Event _____

Effective Benefit Date _____ Verified by _____ Date _____

This form must have an Employer Verification Signature in order to be processed.

Important Information Regarding Health Care and Dependent Care Flexible Spending Accounts

To learn more about FlexChoice, please visit our website at www.sentinelgroup.com. You will find everything you need, including:

- Claim forms
- Information on eligible expenses, including over-the-counter items
- Status information on claims and outstanding balances
- Everything you need to know about benefits debit card

... and much more!

You can only elect to participate in this program during your company's open enrollment period – unless you are new to your company or have experienced a qualified status change. Only the following events will be considered a qualified change in status under IRS guidelines:

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

You must provide the appropriate documents for a Change in Status, e.g. marriage or birth certificate.

Any change in your annual election due to a qualified status change is only valid for expenses incurred from the date of the status change through the end of the plan year.

For answers to specific questions, email us at flexhelp@sentinelgroup.com or call the Sentinel Benefits member Service Center at 888-762-6088 Mon. - Fri., 8:00 AM to 6:00 pm ET (excluding holidays).