Redwood Health Services

Benefits Card Enrollment and Agreement

Return this form to your employer, not to RHS.

Employer ________________ Employer Tax ID # ________________ FSA Plan Year ________

Employee Last Name ________________ First ________________ MI ____ Date of Birth _____/_____/_____

Address ________________ City ________________ State ______ Zip __________ New Address? Y N

Employee SS# ________________ Phone ________________ Marital Status ______________ Gender ☐ M ☐ F

Date of Hire ____________ Eligibility Date if New Hire/Rehire ____________ E-mail ________________

EMPLOYER FSA FUNDING

Annual Medical FSA benefit per employee $________________ per employee/spouse/children/family $________________

EMPLOYEE FSA FUNDING

Payrolls in Plan Year______ Date of first contribution _____/_____/_____ ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Medical FSA Plan

$ ____________ Maximum employer allowed

$ ____________ Annual election

☐ **I elect to waive coverage**

Dependent Care FSA (Non Medical)

$ ____________ Maximum employer allowed

= $ ____________ Annual election ($5,000 max if married filing jointly)
($2,500 max if married filing separately)

☐ **I elect to waive coverage**

List FSA or HRA dependents below:

Social Security #	Last Name First Name MI	Relationship	Date of Birth	Gender	Extra Card
				☐ M ☐ F	☐
				☐ M ☐ F	☐
				☐ M ☐ F	☐
				☐ M ☐ F	☐

FSA Plan Agreement ☐ **I understand and agree that:**

I may elect coverage under any or all of the above components. I cannot change or revoke this FSA agreement during the plan year, unless the plan administrator determines that I will have incurred a qualifying change in status under IRS Code Section 125. Any funding provided by me will be withheld from my paycheck on a pre-tax basis. Participation in this plan reduces my social security withholdings and could reduce my social security benefits. Completion of this form does not guarantee insurance coverage will be initiated. In most cases, an application for insurance must also be completed. Reimbursement will be available only for eligible expenses under IRS Code Section 125. Any unused contributions at the end of the plan year shall be retained by the plan to offset administrative expenses and costs.

Benefits Card Holder Agreement ☐ **I understand and agree that:**

My employer and/or I have the right to **suspend or terminate** my card. Any violation of my cardholder agreement will result in **suspension or termination** of my card. Fraudulent use of my card under the limitations set forth by my employer and the IRS Code Section 125 regulations includes but is not limited to: purchase of non-eligible products or services; purchases for ineligible individuals; providing card access to inappropriate individuals; false claim submission to document transactions; failure to make the necessary fund replacement in my Reimbursement Account. These terms also apply to any extra cards that I may order. I must retain all my RHS Benefits Card receipts for my records in the event the IRS and/or RHS need to audit my account for Code Section 125 compliance.

I certify that I have read, understand and agree to the terms above. **Number of extra cards @ $5.00 per card: _____ Additional benefits card monthly fee $2.50**

Employee's signature:________________________________ **Date:** ________________

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