FLEXIBLE SPENDING ACCOUNT
ONLINE ENROLLMENT INSTRUCTIONS

Online enrollment is only for employees who are currently in the Plan or have participated in the Plan previously. First time enrollees will need to submit a paper FSA enrollment form, see page 2.

Online Enrollment will be available Monday, October 23rd 2017 and will close midnight Thursday, November 9th, 2017.

ENROLL ONLINE

Before a participant may enroll online, an account must be established on the employee Flex web site: **www.myflexonline.com**. To better help you in the online process, below are steps to follow to elect your **2018** Flex Spending benefit(s).

- Visit employee Flex web site: **www.myflexonline.com**
- If a **Registered Participant**, log in with user name and password. If you do not recall your user name and password, click **Password Reset & User Name Retrieval** highlighted in blue. If you need assistance, please contact Custom Benefit Services at (800) 809-8161.
- If this is first time visiting site, click **New User** to create an account.
- Hover over **ENROLLMENT** tab on blue ribbon bar at top and click START Enrollment link at bottom
- Enter **Election Amount** without the dollar sign or a comma in the Medical, Dependent Care (daycare) or both and click **tab key.** (Per pay period amount will be reflected and will be based on annual amount divided by number of pay periods. If the annual amount is not equally divisible by the number of pay periods, the system will adjust/lower the annual amount so as not to go higher than Plan cap/max amount).
- **DEPENDENT CARE IS FOR DEPENDENT DAYCARE BENEFIT**.
- **UNREIMBURSED MEDICAL IS FOR PRESCRIPTION, MEDICAL, VISION & DENTAL REIMBURSEMENT**.
- Click blue **NEXT.**
- Verify New Year Elections. If want to change annual election amount, click **Previous** tab at bottom.
- Click blue **Submit (see Enrollment Confirmation; including confirmation number)**
- **Print a copy** using your browser Print feature (File/Print).
- If during online enrollment period, (you have already visited the site and made an election) and choose to make a change to the existing election, please follow the same steps as above. Be sure to click **Submit** to receive new confirmation number and to print a copy of election. If you choose to delete an election in a benefit, please contact Custom Benefits to confirm the deletion of the benefit has been completed.

IF YOU CURRENTLY HAVE A *TAKE CARE* DEBIT CARD:

- ***Please view your card expiration date (on front of debit card) to determine when to order a renewal card.***
- If enrolling in the 2018 Plan Year and your card is expiring or has expired and your account has a balance to claim of at least $12.00 (debit card fee), a renewal card may be ordered. (Follow same instructions as first time orders below). Otherwise, at end of Open Enrollment, a card may be ordered when election has been posted. For those whose card expires later than **12/31/17** and who is enrolling in the 2018 Plan Year; please focus on timing of card expiration. ****$12.00 annual fee** will be assessed to **available account balance**.
- May opt to order additional cards at no additional fee. Hover over tab at top **CARD CENTER,** and then click **Flex Benefits Card**. Click blue **Get Started** tab at bottom.
- **IF YOU NO LONGER WANT AN ACTIVE DEBIT CARD AND YOU ENROLL ONLINE, YOU MUST NOTIFY CUSTOM BENEFIT SERVICES IN WRITING.**

FIRST TIME TAKE CARE FLEX CARD APPLICANTS or CARD HAS EXPIRED:

- Hover over **CARD CENTER** tab at top, and then click **Flex Benefits Card**. View FAQs to understand use of card.
- $12.00 annual fee will be assessed to available account balance. (Available balance must be equal or greater than fee. If not, (at end of Open Enrollment, once future Plan year election is posted), a card may be ordered.
- To order card and to order additional cards at no additional fee, click blue **Get Started** tab at bottom
- All new and renewal Card(s) will have a 3 year expiration date.

FLEX DEBIT CARD OPTION

ENROLLMENT FORM for the FLEX BENEFITS PLAN

PLEASE PRINT. All information is required or your enrollment cannot be processed.

Employer _____ Employee ID # _____

Employee Name *(First, Last)* _____

Social Security Number _____-_____-_____ Date of Birth (MM-DD-YYYY) _____-_____-_____

Mailing Address _____ Apt._____

City _____ State _____ Zip _____

Phone Number _____-_____-_____ E-mail _____

Employer to complete or enrollment cannot be processed. Plan year start (mm/dd/yy) ___/___/___ and end ___/___/___
First payroll start date___/___/___. No. of Pays_____.

OPTION 1 Health Care Account – Flexible Spending Account (FSA)

❑ YES – I elect to contribute $_____ *(before taxes)* for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified out-of-pocket healthcare expenses that are not covered by my employer's health plan or any other health plan. **Maximum contribution – $2650.00 per year**. (IRS may increase/decrease this amount periodically.)

❑ NO – I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 Dependent Day Care Account

This pays for daycare expenses for a dependent child, adult or elder, so that you may work. Eligible services include: nursery school, nanny and/or before/after school care through age 12, day care for a disabled adult or child, elder daycare for parent or dependent, day camp through age 12.

❑ YES – I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified dependent day care or elder care expenses. **Maximum contribution $5000.00.**

❑ NO – I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

YOU MAY ENROLL IN THE FOLLOWING BENEFITS ONLY IF THEY ARE OFFERED BY YOUR EMPLOYER. Check your Summary Plan Description or ask your employer.

OPTION 3 Agreement to Save Taxes on Insurance Premiums

❑ YES – On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

	Salary Reduction Amount Per Pay Period	No. of Reductions Per Year
Group Medical		
Dental Coverage		
Short Term Disability		
Cancer		
Vision		
Accident		
Other		

OPTION 4 Debit Card

❑ YES – I would like the use of a debit card for my account. There is an annual charge of $_____ for participant's card only. The fee will be deducted from your Flex Account.

Spouse or Dependent's full name for 2nd take care flex benefits card *(First, Last)* _____

❑ NO – I decline the use of a debit card for my account.

IMPORTANT – *Please read the following before signing this enrollment form.* My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections (Options 1 through 2) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I understand that the take care debit card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the take care debit card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

IMPORTANT: Cosmetic and elective procedures are not eligible for reimbursement. Please note, vitamins and supplements require a letter of medical necessity from your doctor. To view account balance, claims information, and "what's covered" – visit www.myflexonline.com.

Employee signature _____ Date _____

White – Custom Benefit Services Yellow – Employer Pink – Employee

Fax (352)-369-9461