



Enrollment Form Employee Reimbursement Account and Pre-Tax Premium Payment

Please be sure to completely and accurately populate this enrollment form with your annual election(s). The completed form must then be returned to your benefits department prior to the end of your Open Enrollment period, to be used to create your elections at WageWorks.

Employee Information

Name		Social Security Number	
Home Address	City	State	Zip
Employer Name	Effective Date / /	Location/Class	Date of Birth / /

Employee Reimbursement Account Agreement

I agree to have my gross salary redirected, in accordance with Section 125 of the Internal Revenue Code, to contribute in the amounts indicated below. I understand that contributions to my reimbursement account(s) can only be reimbursed to me for eligible expenses incurred within each plan year. For example, funds in the Medical Reimbursement Account cannot be used for reimbursement of dependent care expenses. I further understand that if I do not use the funds in my reimbursement account(s) during the plan year, those funds will be handled in accordance to my current plan design offered by my employer.

Medical Reimbursement Account \$ _____ x _____ = \$ _____
(Per Pay) (Pays/Year) (Plan Year Election)

General Purpose (all qualifying medical expenses) OR Limited Purpose (vision and dental expenses only).
 You must select a Limited Purpose Account if you, your spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else.

Dependent Care Reimbursement Account \$ _____ x _____ = \$ _____
(Maximum per plan year of \$2,500 if married filing separately or \$5,000 if single, or married filing jointly; if more than \$2,500 is elected, my signature on this agreement certifies I am single or married filing a joint income tax return with my spouse.)
(Per Pay) (Pays/Year) (Plan Year Election)

I ELECT NOT TO PARTICIPATE.

Automatic Reimbursement Authorization (If this section is not marked, previous plan year election will be maintained)

I have read and understand the information on the back of this form regarding automatic reimbursement. I hereby authorize WageWorks to treat my medical claims as if they are made under both the medical plan and the Medical Reimbursement Account. None of my spouse, dependents, or myself make contributions to an HSA or receive HSA contributions from anyone else.

This election shall remain in force until revoked by me by checking this box: Please revoke this election.

Direct Deposit Authorization (If this section is not marked, previous plan year election will be maintained)

I have read and understand the information on the back of this form regarding direct deposit of reimbursements. I hereby authorize WageWorks to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my account. This election shall remain in force until revoked by me.

Account Number _____ Transit ABA Routing # _____

Account Type Checking Savings This agreement is: New Change Cancel

Name of Bank _____ Bank Phone _____

Pre-Tax Premium Payment Agreement

I agree to have my gross salary redirected to pay my contributions/premiums for employer provided benefits I elect which are payable through the flexible benefits plan. I instruct my employer to make these contributions on my behalf. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, I understand that my salary redirection will automatically be adjusted to reflect that increase or decrease.

Employee Authorization

I have read and understand the above agreement. I authorize my employer to redirect my salary according to this agreement and I will review my paycheck to verify that my employer has made appropriate withholding consistent with my election.

Employee Signature _____ Date _____/_____/_____

This salary redirection agreement for my reimbursement account(s) and the Pre-Tax Premium Payments will continue until:

- I terminate employment with the employer listed above: or
- I have a qualifying status change (see Summary Plan Description) and I modify this agreement consistent with the change; or
- The end of the current plan year; or
- My employer terminates, suspends, or modifies this plan or the benefits under the plan

Automatic Reimbursement Authorization

This option allows eligible medical expenses that have been submitted to your Wellmark health insurance plan to also be considered as a Medical Reimbursement Account claim. After claims are processed by WageWorks the eligible medical expenses will automatically be directed to your Medical Reimbursement Account for further consideration. This option is not available for Limited Purpose Medical Reimbursement Accounts (i.e., if you, your spouse, or dependents make contributions to an HSA or receive HSA contributions from anyone else).

I am enrolled in a Medical Reimbursement Account administered by WageWorks. I hereby authorize WageWorks to treat my claims as if they are made under both the medical plan and the Medical Reimbursement Account. WageWorks will use the Medical Reimbursement Account to reimburse me for deductible, coinsurance, and copayment amounts eligible under IRC Section 213(d). Contract limitations will need to be filed manually. Furthermore, I certify that:

- **I have no other insurance coverage.** No family members covered under my medical and/or dental contracts have other insurance which covers the charges referenced above. If other coverage is obtained during the plan year, I will notify my employer immediately and revoke this agreement.
- **Neither my spouse, my dependents, nor I make contributions to an HSA or receive HSA contributions from anyone else.**
- **Only legitimate claims will be submitted.** All claims submitted to the WageWorks medical plan(s) will be for expenses that are reimbursable under the terms of the Medical Reimbursement Account. I will not submit paper claims to the Flexible Benefits Department if these charges will be processed by the medical plan(s), since these claims will automatically be forwarded to my Medical Reimbursement Account.
- **I understand that previously processed claims will not be automatically reimbursed.** Claims incurred prior to the effective date of this authorization will not be reimbursed through this program and must be submitted manually.
- **I understand that automatic reimbursement will not be possible if different identification numbers are used.** If a medical claim is processed under an identification number that is different than the number under which the Medical Reimbursement Account is listed, the unreimbursed charges arising from the claim will not be automatically applied to my Medical Reimbursement Account.

Direct Deposit Authorization

<ul style="list-style-type: none"> • The Transit ABA routing # includes all of the numbers between the colons. Be sure to include any zeroes at the beginning or end. • The Account Number includes all of the numbers after the second colon and before the mark "⑈". Be sure to include any zeroes at the beginning or end. 	<table border="1"> <tr> <td>JOHN PUBLIC 123 Main Street Your Town, FL 12345</td> <td style="text-align: right;">1234</td> </tr> <tr> <td>PAY TO THE ORDER OF _____</td> <td style="text-align: right;">\$ <input type="text"/></td> </tr> <tr> <td>Your Town Bank Your Town, FL 12345 For _____</td> <td style="text-align: right;">DOLLARS</td> </tr> <tr> <td colspan="2" style="text-align: center;">⑆250000005⑆ : 4234556789022⑈</td> </tr> <tr> <td style="text-align: center;">Routing Transit Number</td> <td style="text-align: center;">Account Number</td> </tr> <tr> <td colspan="2" style="text-align: center;">NOTE: THE ACCOUNT AND ROUTING NUMBER MAY APPEAR IN DIFFERENT PLACES ON YOUR CHECK.</td> </tr> </table>	JOHN PUBLIC 123 Main Street Your Town, FL 12345	1234	PAY TO THE ORDER OF _____	\$ <input type="text"/>	Your Town Bank Your Town, FL 12345 For _____	DOLLARS	⑆250000005⑆ : 4234556789022⑈		Routing Transit Number	Account Number	NOTE: THE ACCOUNT AND ROUTING NUMBER MAY APPEAR IN DIFFERENT PLACES ON YOUR CHECK.	
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Note: If you are requesting direct deposit, you must attach a voided check for verification and reference. For any requests other than the beginning of your plan year, it will take two check cycles for the direct deposit authorization to be processed.