American Printing House for the Blind 1.1.20-12.31.20 Flexible

Spending Account Certification Enrollment Form

EMPLOYEE INFORMATION

Employee Name: DOB: SSN:

Address:

City: State: Zip Code:

Email:

Are you enrolled in Medicare?
If "yes" you must provide your Medicare Claim Number (HICN):

*Section 111 of the Medicare, Medicaid and SCHIP Expansion Act of 2007 requires the plan sponsor to report certain enrollment data to the Centers for Medicare & Medicaid Services (CMS).

FSA ELIGIBILITY INFORMATION (To be eligible for reimbursement of all qualified expenses):

1. I am waiving coverage under my Employer's group health plan.
2. I am covered under another Employer's group health plan.
3. My group health plan coverage meets the Minimum Value requirement under the Affordable Care Act (ACA).
4. My group health plan coverage meets the Preventative Services requirement under the Affordable Care Act (ACA).
5. I certify all my tax dependents and I will be enrolled in other qualifying health insurance coverage that is deemed to be minimum essential coverage under the Affordable Care Act.

SPOUSE AND DEPENDENT HEALTH COVERAGE INFORMATION:

Spouse Name:	DOB:	SSN:
Child Name:	DOB:	SSN:
Child Name:	DOB:	SSN:
Child Name:	DOB:	SSN:
Child Name:	DOB:	SSN:

PLAN AUTHORIZATION:

1. I understand that by enrolling in this plan it makes me and/or my spouse ineligible for an HSA.

2. I understand that I may only use these funds for qualified medical expenses as defined by the IRS incurred by me, my legal spouse and/or dependents.
3. I certify that I am covered under another Group Health Plan (GHP) that meets the Minimum Value and Preventative Services requirements under the Affordable Care Act (ACA).
4. I understand that if I am not covered under another GHP that meets the above requirements, I'm not eligible to participate in the FSA.
5. I understand that if at any time during the plan year, I am not covered a GHP that meets the Minimum Value requirements, I am technically ineligible for reimbursements and I will be indebted to my employer for any ineligible reimbursements received.
6. I understand that my coverage ends upon my termination of employment or my failure to meet the eligibility requirements under the Plan. I will have 90 days after my coverage ends to submit any eligible expenses for reimbursement.
7. If at any time during the plan year myself or one of my covered dependents becomes entitled to or enrolled in Medicare or Medicaid I will report this information to my Employer and McGregor & Associates.

Employee Signature: Date: