HR/Payroll Please Complete:

Effective Date of Coverage:

American Printing House for the Blind
FSA CAFETERIA PLAN ENROLLMENT FORM
01.01.2020-12.31.2020

Employee Information Below:

Employee Name: SSN:

Address:

City: State: Zip Code:

PLAN ELECTIONS OF PRE-TAX BENEFITS

Flexible Spending Account

Do you elect to participate in the Flexible Spending Account? (*General Purpose)* Out-of-pocket medical, dental and vision expenses. *Annual contribution limits: Maximum $2,750. $250.00 Quarterly Contribution made by American Printing House for the Blind.*

Type Yes or No for FSA:

Dependent (Child) Care Reimbursement Account

Child and/or adult daycare expenses. *Annual contribution limit: Maximum $5,000. (If you are married and file separate tax returns, limit is $2,500)*

Type Yes or No for Dependent Care Account:

Election Amount: Indicate amount per pay period $, for a total of for plan year.

Direct Deposit Information

DIRECT DEPOSIT-To receive reimbursement for paper/manual claims directly to your bank account via ACH.

Bank Name:

Is this a checking or savings account:

Nine Digit Routing Number:

Bank Account Number:

*I understand that if I do not choose to sign up for direct deposit as the reimbursement method for manual/paper claims, I may be responsible for a $32 stop payment fee for any lost or stolen checks.

I hereby authorize my Employer to deduct from my salary the required contributions for the amounts I have elected above. I agree and understand that I cannot change my election once the plan year begins unless I experience a qualifying event as defined under the Plan and by the Internal Revenue Code (IRC).

I agree to comply with the terms of the Plan, which are reflected in the Summary Plan Description (SPD). I acknowledge I have received and read all of the information provided on page 2 of this Form.

Employee Signature: Date:

GROUP HEALTH INSURANCE COVERAGE AUTHORIZATION:

I understand that:

If I choose to participate in any group health plan and I am required to pay a portion of the premium, this amount is automatically deducted pre-tax. If I do not wish to have my premiums deducted pre-tax, I must obtain a waiver from my Human Resources Department. I may not change my coverage election during the plan/policy year unless I experience a qualifying event as defined by the Cafeteria Plan and the Internal Revenue Code (IRC).

FLEXIBLE SPENDING ACCOUNTS AUTHORIZATION:

I understand that:

I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year, or by the end of the 2 1/2 month grace period (if applicable). I must submit my claims, incurred during the current plan year or during the 2 1/2 month grace period (if applicable) by the end of the"run-out" period, or the funds will be forfeited according to the IRS rules.

I cannot change my election once the Plan Year begins; my elections must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or a change in employment status.

My out-of-pocket expenses must be incurred while I am an eligible participant and the expenses must be incurred during the current plan year or the 2 1/2 month grace period (if applicable), to be eligible for reimbursement. The date of service, not the Invoice date, must be incurred during the current plan year.

If I terminate employment, I can only be reimbursed for expenses incurred during the current plan year and prior to my termination date. I may have additional time to submit my claims after my termination date if the Plan allows.

I cannot itemize and deduct my out-of-pocket expenses on my IRS Form 1040 for any accounts I am enrolled.

DIRECT DEPOSIT AUTHORIZATION:

I understand that:

If I have chosen to receive payments for my reimbursement accounts via direct deposit, I authorize my financial institution to receive transactions via electronic transfer initiated by McGregor & Associates, Inc.

I permit McGregor & Associates, Inc. to initiate electronic credit entries, and if necessary, debit entries to reverse erroneous credits to the account I designated on this Form.

Direct Deposit of my reimbursements shall commence within 4 weeks of receipt of this Form.

My direct deposit may be terminated by: a written cancellation request submitted by me at least 7 business days prior to the next scheduled deposit date, a failed bank transmittal due to incorrect bank information provided by me, or by logging into my online web portal via www.mcgregoreba.com.

McGregor & Associates, Inc. reserves the right to charge a $32 fee for any failed or returned transmittal due to incorrect bank account information provided by me.

DEBIT CARD AUTHORIZATION:

I understand that:

As a participant in the Flexible Spending Accounts sponsored by my Employer, I may choose to receive a benefits pre-paid Visa debit card. I agree to use the card in accordance with this Agreement and the Cardholder Agreement that will be received with the card.

I understand that the benefits card is restricted to certain merchant categories and is not accepted at all Visa locations. I understand that I may not obtain a cash advance with the card at any merchant, bank or ATM. I understand that the benefits card is to be used exclusively for qualified expenses as defined by the Plan in which I participate. If the card is used for an expense that is not a qualified expense, I am indebted to my Employer and must repay the full amount of the non-qualified expense.

I agree to save all invoices and receipts related to any purchases made with my benefits card and upon request, I must submit these documents for review by McGregor & Associates, Inc. Failure to submit the requested receipts(s) within the timeframe allotted, will result in suspension of my card use. In the event I fail to supply the appropriate documentation, I understand the expense will be treated as a non-qualified expense and I will be required to repay the amount to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, or a post-tax deduction from my paycheck I understand that my Employer reserves the right to withhold any ineligible or unsubstantiated expenses from my paycheck post-tax.

If I terminate employment, or lose eligibility under the Plan, my benefits card will become inactive.

End of Form