

GettHealth FSA/HRA Enrollment Form

Group Number: _____

HEALTH REIMBURSEMENT ARRANGEMENT ENROLLMENT INFORMATION

EMPLOYER NAME _____

Effective Date (As of): _____

SOCIAL SECURITY # _____

LAST NAME _____

FIRST NAME _____

MI _____

GENDER: MALE FEMALE

DATE OF BIRTH: / /

DATE OF HIRE: / /

ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

PHONE #: () _____

MARITAL STATUS: Single Married Divorced Separated Widow

EMAIL*: _____

COVERAGE TIER*: SINGLE NON-SINGLE

DEPENDENT INFORMATION:

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

Name: _____ SSN: _____ DOB: _____ SEX: _____

** If you check Non-single coverage tier, complete the dependent information area.*DOES THE EMPLOYEE MAKE AN ANNUAL SALARY THAT IS LESS THAN \$25,000? YES NO

(information is only required if employee is electing a health care FSA or dependent care account)

EMPLOYER HR USE ONLY (CHECK ALL THAT APPLY):

-
- KEY EMPLOYEE
-
-
- HIGHLY COMPENSATED EMPLOYEE
-
-
- EMPLOYEE WHO IS 5% OR MORE OF A COMPANY SHAREHOLDER

HR USE ONLY (check one):

-
- HRA PLAN ONLY
-
-
- FSA PLAN ONLY
-
-
- FSA & HRA PLANS

FLEXIBLE SPENDING ACCOUNT ENROLLMENT INFORMATION

Please read and fill out the information in this section if your company sponsors a flex spending account plan and you are electing to participate in it.

If you participate in your employer's insurance plan(s), your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department.

I understand that the rules of IRC Section 125 allow me to use part of my salary on a Pre-Tax basis to purchase one or more of the following benefits. I hereby elect to participate in my employer's Section 125 Flexible Benefits Plan as indicated below. Please fill in your election amount per account (if zero for either account, please so state "Zero") in the top section of page 2:

Benefits Election Options	Guidelines	Total Annual Amount
Health Care Flexible Spending Account	Maximum of \$ _____ per plan year	\$ _____
Dependent Care Flexible Spending Account	Maximum of \$ _____ per plan year* * if married and filing separately, maximum \$2,500 per plan year	\$ _____

This election will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are as a result of a change in family status (e.g. my marriage or divorce, death of my spouse or dependent, birth or adoption of my child, commencement or termination of employment of my spouse, my or my spouse's unpaid leave of absence or change from full-time to part-time employment (or vice versa), and such other events as the Plan Administrator determines will permit or change revocation of an election). I understand that if I have a change of family status, I must notify the Plan Administrator within thirty (30) days of this change in order to modify or revoke this benefit election during the calendar year. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the benefits(s) as shown above, for the Plan Year of _____ through _____. I understand that if I begin or cease participation during the Plan Year, amounts contributed shall accrue on my behalf only during the period in which I participate. Additionally, the maximum amounts I may contribute will be prorated based on my actual participation period.

YES, the benefits of this plan have been explained to me and I elect to participate as indicated above, and I would like to enroll.

X _____
Employee's signature Date

No, I do not want to enroll in the voluntary reimbursement sections.
If a change of status occurs, I may have the right to sign on the plan at that time if my employer's plan allows.

X _____
Employee's signature Date

Authorization for Use or Disclosure of Protected Health Information for HRA/FSA Administration

I authorize the use/disclosure of health information from the HRA and/or FSA financial account as it pertains to / about me as described below.

- Person(s) or class of persons authorized to use/disclose the information:
Gettysburg Health Administrators, Inc., my employer and my Human Resource personnel.
- Person(s) or class of persons authorized to receive the information:
Gettysburg Health Administrators, Inc., my employer and my Human Resource personnel.
- Description of information that may be used/disclosed:
Financial Information as it pertains to the Health Reimbursement Arrangement and/or Flexible Spending Account, specifically, date of service, and provider/facility name (similar to the information received on a credit card bill)
- The information will be used/disclosed for the following purposes:
Tracking of financial information for my employer's Health Reimbursement Arrangement and/or Flexible Spending Account
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that I may revoke this authorization in writing at any time

This authorization expires upon the HRA and/or FSA plan termination with Gettysburg Health Administrators, Inc. acting as administrator.

_____/_____/_____
Signature of Participant Date