

# Employee Enrollment Form– Section 125

**Administered By: GETTYSBURG HEALTH ADMINISTRATORS**

34 Locust Ave, P.O. Box 1060 Gettysburg, PA 17325-1060

Section 125/Cafeteria Plan

New Enrollment

Add Dependent

<b>SHADED AREA FOR OFFICE USE ONLY</b>	<b>GROUP #:</b>	<b>EFFECTIVE DATE:</b>	<b>PROCESSED BY:</b>	<b>DATE :</b>
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Employee Name:	Phone:
Full Address:	
Date of Full-Time Employment:	Email:

	SEX M/F	DATE OF BIRTH	SOCIAL SECURITY	HEIGHT FT - IN	WEIGHT
<b>INFORMATION ON EMPLOYEE TO BE INSURED:</b>					

<b>Employer Name:</b>	Are you covered by Workers' Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Job Title/Duties:</b>	Insurance Class:

**Are you working your regular work week with this employer:**  
 Yes Weekly Hours: \_\_\_\_\_ Earnings: \_\_\_\_\_ Payroll cycle:  Annual  Weekly  Bi-Weekly  Hourly  
 No - Reason:  COBRA  Retired  Disabled  Other \_\_\_\_\_

**Marital Status:**  
 Single  Married  Widowed  Divorced  Legally Separated

DEPENDENTS TO BE INSURED: (last name if different)	RELATIONSHIP (spouse; child)	SEX M/F	DATE OF BIRTH	SOCIAL SECURITY	HEIGHT FT - IN	WEIGHT

**BENEFIT ELECTION, SIGNATURE AND DATE MUST BE COMPLETED ON ALL PAGES.**

- MERP/HRA (Medical Expense Reimbursement Program / Health Reimbursement Arrangement)
- HCR FSA (Health Care Reimbursement FSA)
- DCR FSA (Dependent Care Reimbursement FSA)

**SHADED AREA FOR HUMAN RESOURCE USE ONLY:**

DOES THE EMPLOYEE MAKE AN ANNUAL SALARY THAT IS LESS THAN \$25,000  YES  NO

- (Check all that apply)
- KEY EMPLOYEE
  - HIGHLY COMPENSATED EMPLOYEE
  - EMPLOYEE WHO IS 5% OR MORE OF A COMPANY SHAREHOLDER

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 Reimbursement Account		\$ _____

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 \_\_\_\_\_

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## Authorization for Use or Disclosure of

### Protected Health Information for HRA/FSA/MERP Administration

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

1. Person(s) or class of persons authorized to use/disclose the information:

**Gettysburg Health Administrators, Inc., my employer and my Human Resource personnel.**

2. Person(s) or class of persons authorized to receive the information:

**Gettysburg Health Administrators, Inc., my employer and my Human Resource personnel.**

3. Description of information that may be used/disclosed:

**Financial Information as it pertains to the Flexible Spending Account, Health Reimbursement Arrangement, Medical Expense Reimbursement Plan: specifically, date of service, and provider/facility name (similar to the information received on a credit card bill)**

4. The information will be used/disclosed for the following purposes:

**Tracking of financial information for my employer's Flexible Spending Account, Health Reimbursement Arrangement, Medical Expense Reimbursement Plan**

5. 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.

6. I understand that I may revoke this authorization in writing at any time

**This authorization expires upon the HRA, FSA, MERP plan termination with Gettysburg Health Administrators, Inc. acting as administrator.**

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\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Signature of Participant**

**Date**