Flexible Spending Account (FSA)
Enrollment Form

MUTUAL HEALTH SERVICES℠

By selecting an FSA, you're making a smart decision to set aside pre-tax dollars to pay for eligible healthcare expenses. If you think you'll have medical expenses that won't be reimbursed by another plan, FSAs are a great way to save money while covering those costs.

Fill out your personal information on the back of this form and select the FSA(s) that are right for you. Talk with your employer to find out any contribution limits and which plans are available for your company.

Please complete and return the form based on your employer's instructions.

Note: If your employer asks you to complete the fillable PDF and return the form via email, please complete all fillable fields as noted and save this PDF form with a new file name, such as:

Example: John_SmithFSA.pdf

Please follow your employer's directions regarding specific formatting and email return instructions or contact your employer with any questions. To download the free Adobe PDF Reader, visit:

https://Acrobat.Adobe.com/US/EN/Acrobat/PDF-Reader.htm

Mutual Health Services FSA Options

Option 1A — Mutual Health Services Flexible Spending Account (FSA)*

The FSA reduces your taxable income by setting aside pre-tax dollars to pay for eligible healthcare expenses.

Option 1B — Mutual Health Services Limited-Purpose Flexible Spending Account (LPF)*

The LPF is available only if you elect to enroll in a health savings account (HSA). The LPF is in addition to your HSA and is limited to paying only qualified dental and/or vision expenses that are not covered by your employer's health plan or any other health plan.

Option 2 — Mutual Health Services Dependent Care/Elder Care Account (DCA)*

The DCA pays for day care expenses for a dependent child, adult or elder, so you may work. Eligible services include: nursery school, nanny, and before-or after-school care/day camp through age 12; day care for a disabled adult or child; and elder day care for parent or dependent.

*Account contributions are subject to IRS regulations and are subject to IRS limits. Based on IRS limits, your employer will determine contribution limit for your account. Please review your Summary Plan Description for contribution levels. You may contribute up to this amount for the plan year. This annual election amount will be deducted evenly out of each pay check on a pre-tax basis and deposited into your account.

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Member Information			
Employer			Hire Date (MM/DD/YYYY) MM/DD/YYYY
Employee First Name	Employee Last Name		Birthdate (MM/DD/YYYY) MM/DD/YYYY
Street Address			
City		State	ZIP
SSN	Primary Phone (###) ###-###	Email	

Authorization

IMPORTANT Please read the following before signing this enrollment form.

My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that the Mutual Health Services debit card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the Mutual Health Services debit card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with the Mutual Health Services debit card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee Signature	Date (MM/DD/YYYY) MM/DD/YYYY

Account Options

Option 1A — Mutual Health Services Flexible Spending Account (FSA)

☐ **Yes** I elect to contribute **A** (before taxes) for the PLAN YEAR*, which is **B** per pay period, to fund my account that pays qualified out-of-pocket, healthcare expenses that are not covered by my employer's health plan or any other health plan.

A: $ _____ B: $ _____

☐ **No** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

Option 1B — Mutual Health Services Limited-Purpose Flexible Spending Account (LPF)

☐ **Yes** I elect to contribute **A** (before taxes) for the PLAN YEAR,* which is **B** per pay period, to fund my account that pays qualified out-of-pocket, healthcare expenses not covered by my employer's health plan or any other health plan.

A: $ _____ B: $ _____

☐ **No** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

Option 2 — Mutual Health Services Dependent Care/Elder Care Account (DCA)

☐ **Yes** I elect to contribute A (before taxes) for the PLAN YEAR, which is B per pay period, to fund my account that pays qualified dependent day care or elder care expenses.

A: $ _____ B: $ _____

☐ **No** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

*Account contributions are subject to IRS regulartions and are subject to IRS limits. Based on IRS limits, your employer will determine contributions limit for your account. Please review your Summary Plan Description for contribution levels. You may contribute up to this amount for the plan year. This annual election amount will be deducted evenly our of each pay check on a pre-tax basis and deposited into your account.