Flexible Benefits Plan
Enrollment Form
July 1, 2018 – June 30, 2019 Plan Year

Employee (Last Name, First, Middle Initial)	Social Security No.	Hire Date	Effective Date
Mailing Address		Email Address	

INSURANCE PREMIUM PLAN

This Plan allows you to pay with pre-tax dollars your share, if any, of the cost for health insurance premiums for you and, if enrolled, any of your dependents covered under your employer-sponsored health insurance plans as permitted under Section 125 of the Internal Revenue Code.

If you are newly eligible for the plan, and when you have signed an enrollment form electing insurance coverage for you or your dependents, we will automatically treat that election as an election to pay your share of premiums with pre-tax dollars, beginning on the date you become a participant in the Premium Payment Plan. However, if you wish, you may elect to pay federal income, social security and state taxes on your share of the insurance premiums. If you wish to pay these taxes, please ask the Human Resources Department for the appropriate "Pre-tax Premium Waiver" form.

Whichever option you elect, you may not change or revoke your election until the open enrollment period for the next plan year. Each plan year you will have the opportunity to elect in or out of the Premium Payment Plan during the open enrollment period, which is typically the month prior to the beginning of the plan year.

Once you have elected to participate in the Premium Payment Plan, your election will continue until the next plan year. You may change your election during the plan year only if there is a qualified change in your family status (e.g. marriage, divorce, death, birth of a child) and such other events as the Plan Administrator determines will permit change or revocation of your election. Your Summary Plan Description has more information.

HEALTH CARE EXPENSE REIMBURSEMENT PLAN

CHECK HERE IF YOU WANT A DEBIT CARD ❒

This is the self-funded account for health related expenses that are not covered by health insurance for you and your tax dependents. **Do Not Include Any Premium Amounts**

	Pay Period Deduction	# of Pay Periods	Total Annual Election
Health Care Account (Minimum $120 and Maximum $2,650)	$_____	X_____	$_____

DEPENDENT DAY CARE REIMBURSEMENT PLAN

This is the self-funded account for **daycare** expenses for your children or other tax dependents.

	Pay Period Deduction	# of Pay Periods	Total Annual Election
Day Care Account (Calendar Year Dependent Care Max: = $5,000)	$_____	X_____	$_____

EMPLOYEE'S STATEMENT

I have received and read printed materials explaining my employer's Flexible Benefits Plan and my options as a participant. I understand that I am making a binding election for one full plan year; that elections can be changed only during open enrollment or, in some cases, when permitted under the plan's rules.

Participation in the flexible benefits plan creates Personal Health Information. Unless otherwise directed by me, BAC will anticipate that they are authorized to communicate with my spouse regarding my flex account for the purposes of claims question, denials, balances, and other operations of the account. This release is revocable at anytime by completing the Release of Information form. If you would like to limit the information available to your spouse or allow access to other dependents please complete the Release of Information form.

I acknowledge that I have read the terms of the Benefits Debit Cardholder Agreement and understand that receipts are required and that failure to submit documentation when requested may result in: a) the expense being deemed ineligible in which case I would be obligated to repay the amount to my Benefit Plan; b) immediate suspension or revocation of my card; c) taxable payroll deductions of the ineligible expenses; d) taxable gross income being subject to an additional tax on that amount.

Date	**Signature of Employee**