RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

# FLEXIBLE BENEFITS PLAN ENROLLMENT — PLAN YEAR 2017

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

**Complete this form only if you wish to participate in the Medical, Limited Purpose or Dependent Care Reimbursement Account**

## EMPLOYEE INFORMATION

| LAST NAME | FIRST NAME | MIDDLE INITIAL | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| HOME ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| DEPARTMENT NAME | DEPT ID / BUDGET CODE | DATE HIRED | EMPLOYEE ID (IF KNOWN) |
|---|---|---|---|
| | | | |

| WORK PHONE | PAYROLL FREQUENCY (PAYCHECKS PER YEAR) | ENROLLMENT STATUS |
|---|---|---|
| | ☐ 12 ☐ 24 ☐ Other _____ | ☐ New Hire |

## REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your HR office for additional information or you may call Benefits Administration at 615.741.3590 or 800.253.9981.

If you are enrolled in the HealthSavings CDHP, you are not eligible to contribute to the Medical Expense Account; however, you may contribute to the Limited Purpose Account (for vision and/or dental expenses only).

In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the plan year.

### MEDICAL EXPENSE ACCOUNT

Maximum allowable annual contribution is $2,550

| | | |
|---|---|---|
| Box #1 Reduction per regular paycheck | | |
| Box #2 Number of regular paychecks expected | X | |
| Box #3 Total plan year dollar amount | = | $0.00 |

### LIMITED PURPOSE ACCOUNT

Maximum allowable annual contribution is $2,550

| | | |
|---|---|---|
| Box #1 Reduction per regular paycheck | | |
| Box #2 Number of regular paychecks expected | X | |
| Box #3 Total plan year dollar amount | = | $0.00 |

### DEPENDENT CARE ACCOUNT

**Tax Filing Status (please check one)**

☐ Married, filing separately (maximum $2,500)
☐ Married, filing jointly (maximum $5,000)
☐ Head of household (maximum $5,000)

| | | |
|---|---|---|
| Box #1 Reduction per regular paycheck | | |
| Box #2 Number of regular paychecks expected | X | |
| Box #3 Total plan year dollar amount | = | $0.00 |

## AUTHORIZATION

- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved family status change.
- I understand that any amount remaining in my Dependent Care account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year. I also understand that any funds in excess of $500 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of $500 or less will carry over into the following year if I re-enroll.
- I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.

| EMPLOYEE SIGNATURE | DATE |
|---|---|
| | |

Return this application to your human resource office after making a copy for your records.
For questions regarding enrollment or a family status change, please call Benefits Administration at 615.741.3590 or 800.253.9981.
For questions regarding reimbursement requests, please call PayFlex at 855.288.7936.