Benefits Enrollment Form 2020

USAdmin Services, LLC

USAdmin Services, LLC (Fedco Division)

H/R Information

Employer Name: _____ Department: _____

Benefit Start Date: _____ Date of hire: _____ First Payroll Deduction: _____

Paycheck Frequency (Circle one): Weekly Bi-weekly Semi-Monthly Monthly Other: _____

Participant Information

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____ Birthday: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Mobile/Cell Phone: _____

E-Mail Address: _____ Gender: M / F

Spouse Information

Spouse Name (Additional Card): _____

Social Security Number: _____ Birthday: _____

Dependent Information

Name: _____ Relationship: _____

Social Security Number: _____ Birthday: _____

Name: _____ Relationship: _____

Social Security Number: _____ Birthday: _____

Name: _____ Relationship: _____

Social Security Number: _____ Birthday: _____

Name: _____ Relationship: _____

Social Security Number: _____ Birthday: _____

Benefits *(Check the box of all accounts that apply)*

☐ **Option 1: (DCA) Dependent Care Reimbursement Account** (Circle one)
Single - $2500.00 MAX Family - $5000.00 MAX
I elect to contribute $ _____ before tax, to fund my DCA account. Per Pay / Monthly / Annual

☐ **Option 2: (FSA) Flexible Spending Account**
$2750.00 – Employee MAX
I elect to contribute $ _____ before tax, to fund my FSA account. Per Pay / Monthly / Annual
$500.00 – Employer MAX
My Employer will contribute $ _____ to fund my FSA account.

☐ **Option 3: (HC2) Limited Flexible Spending Account**
$2750.00 – Employee MAX
I elect to contribute $ _____ before tax to fund my HC2 account. Per Pay / Monthly / Annual
$500.00 – Employer MAX
My Employer will contribute $ _____ to fund my HC2 account.

*****Note: If you have a Health Savings Account and elect a Flexible Spending Account it *must* be limited. It is up to the participant to notify FEBCO if they have an HSA plan outside of FEBCO. *****

☐ **Option 4: (HRA) Integrated Health Reimbursement Account**

My Employer will contribute $ _____ to fund my HRA account. Per Pay / Monthly / Annual

☐ **Option 5: (HRA) Waiver Health Reimbursement Account**

My Employer will contribute $ _____ to fund my HRA account. Per Pay / Monthly / Annual

*****Note: If you are waiving your employer provided Health Insurance, you must provide proof of insurance Coverage*****

☐ **Option 6: (HR2) Limited Purpose Health Reimbursement Account**

Employer will contribute $ _____ to fund my HRA account. Per Pay / Monthly / Annual

*****Note: If you do not have Group Health Insurance, you must elect the LIMITED PURPOSE HRA. Examples of Health Insurance that *require* Limited HRA: Tricare, Medicare, Individual plans, etc.**
If you have a Health Savings Account and elect a Health Reimbursement Account it must be limited. It is up to the participant to notify FEBCO if they have an HSA plan outside of FEBCO. ***

Signature *(Incomplete applications will not be processed)*

I have enrolled in certain employer-sponsored insurance benefits. I understand that my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my taxable income will automatically be adjusted to reflect that increase or decrease. My employer and I agree that my taxable income will be reduced each pay period by the amount set forth in this Agreement. I understand that I may change my election in the event of certain changes in my status. 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. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash.

Employee Signature: _____ Date: _____

Fax this form to: (502) 695-9692 or (423) 634-0625
Email to: flex@usadmin.com

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