Do Not Staple

Kentucky Employees' Health Plan
Department of Employee Insurance
kehp.ky.gov ● 1-888-581-8834

2014 Active Employee Flexible Spending Account (FSA) Enrollment/Change Application

To Be Completed by IC/HRG

KHRIS Per Number	Date of Hire	Effective Date	Organizational Unit#	Cost Center#	Company #

Employee's SSN	Name (Last, First, MI)		Date of Birth
Street Address	Home Phone Number	Work Email Address	
City, State, ZIP	Home County	Cell Phone Number	Home Email Address

Reason

- ☐ Rehire
- ☐ New Hire
- ☐ Open Enrollment
- ☐ New Group
- ☐ Qualifying Event (QE) Date: _____
- ☐ Other Reason:

If Qualifying Event, check item below:

- ☐ Divorce/Legal Separation/Annulment*
- ☐ Death of a Child or Spouse*
- ☐ Loss of Eligibility
- ☐ Gaining/Losing other Coverage, Medicare/Medicaid or any Government Group Health Insurance Coverage
- ☐ Gaining/Losing other Coverage
- ☐ Significant Cost Increase or Decrease for Dependent Care FSA*
- ☐ Marriage*
- ☐ Birth/Adoption of Child/Placement for Adoption*
- ☐ Guardianship/Court Order*
- ☐ Military Leave/Leave without Pay Date:_____
- ☐ Other Reason*

*Requires Supporting Documentation

Make Your Elections

Healthcare Flexible Spending Account
(Employee Funded)

☐ I request to **enroll** in a Healthcare FSA and elect $_____ per pay period.

☐ I request to **change** my Healthcare FSA election from $_____ per pay period to $_____ per pay period.

For a total Calendar Year contribution of $_____.
(Calculate full calendar year amount (1/1-12/31). If during mid-year, calculate by the remaining number of paychecks.)

- Maximum Calendar Year contribution is $2,500 per eligible Planholder
- Minimum Calendar Year contribution is $120
- Enter an amount evenly divisible by 24

Dependent Care Flexible Spending Account
(Employee Funded)

☐ I request to **enroll** in a Dependent Care FSA and elect $_____ per pay period.

☐ I request to **change** my Dependent Care FSA election from $_____ per pay period to $_____ per pay period.

For a total Calendar Year contribution of $_____.
(Calculate full calendar year amount (1/1-12/31). If during mid-year, calculate by the remaining number of paychecks.)

- Maximum Contribution per tax filing status: ☐$2,500 married filing separately ☐$5,000 married filing jointly ☐$5,000 single head of household
- Minimum Calendar Year contribution is $120
- Enter an amount evenly divisible by 24

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_____ -_____ -_____
Employee's SSN

Authorization and Certification **I understand and agree that:**

Authorization and Certification for flexible spending account (FSA) elections made by the planholder through the Kentucky Employees' Health Plan (KEHP or Plan), administered by the Department of Employee Insurance (DEI). For the purposes of this Authorization and Certification, FSA refers to a Healthcare Flexible Spending Account and a Dependent Care Flexible Spending Account, collectively. A Healthcare Flexible Spending Account will be referred to as a Healthcare FSA. A Dependent Care Flexible Spending Account will be referred to as a Dependent Care FSA.

My signature on this application for enrollment in an FSA creates a legal and binding contract. By affixing my signature, I understand that:

- If I am enrolling in an FSA during open enrollment, the FSA will be effective the first day of the following plan year. If I am a new employee enrolling in an FSA outside of open enrollment, the FSA will be effective in accordance with my employer's new hire waiting period rules (generally the first day of the second month after a new employee is eligible to enroll in an FSA).
- I have read and understand the 2014 KEHP Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPDs) and the Summary of Benefits and Coverage (SBC).
- All KEHP benefits for my eligible dependents and me will be provided in accordance with the limitations in the SPDs, BSG, and SBCs. I will abide by all terms and conditions governing participation in an FSA and as set forth in the SPD. In the event of a conflict between the terms of coverage stated in the SPDs, the BSG, and the SBCs, the terms of coverage stated in the SPDs will govern.
- KEHP uses third parties, including Humana and Express Scripts, to provide certain administrative functions. KEHP may communicate with me directly or through these third parties about my coverage, my benefits, or health-related products or services provided by, or included in KEHP's plan of benefits.
- The elections indicated by this application may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- Enrollment in an FSA is voluntary. I authorize my employer to deduct from my earnings the amount required to cover my employee contribution to the FSA I have selected, including any arrears I may owe. I authorize payment of my employee contributions to be made on a pre-tax basis.
- Any payment submitted to KEHP that I intend to be used to fund my FSA will first be used to pay other priority debts that may be due and owing such as taxes and child support.
- KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through my employer, I am not eligible for a health insurance premium tax credit if purchasing insurance through the health insurance exchange.
- A KEHP Healthcare FSA may only reimburse me for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. Pursuant to federal law, the cost of over-the-counter medicines (other than insulin and those prescribed by a doctor) may not be reimbursed through my Healthcare FSA.
- If I choose a Dependent Care FSA, I am eligible to seek reimbursement, as authorized by 26 U.S.C. Sections 21 and 129, for dependent care expenses. The Dependent Care FSA may only reimburse dependent care expenses that are incurred during this applicable coverage period.
- Any unused amount remaining in my FSA at the end of the plan year cannot be carried forward to the next plan year.
- My Humana*Access*[SM] Visa® Card will be suspended if the required Healthcare FSA claim verification is not sent to Humana within sixty (60) days after the card swipe. I agree to follow all rules and guidelines established by the Plan concerning the Humana*Access*[SM] Visa® Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from my paycheck, and offset my Healthcare FSA if I fail to properly substantiate a claim.
- I have rights under HIPAA regarding the protection of my health information. KEHP will comply with the HIPAA privacy and security rules, and uses and disclosures of my protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP's Notice of Privacy Practices available at kehp.ky.gov.
- Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. I can be held responsible for any fraudulent act that I could have prevented while acting within my duties related to the KEHP, and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature on this application certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.

Please submit this application to your IC/HRG

Employee Signature _____ Date _____

IC/HRG Signature _____ Date _____