

Section 125 Flexible Spending Account Employee Enrollment Information



What Is an FSA?

Your benefits package includes a Flexible Spending Account (FSA), which allows eligible employees to set aside a specific pretax dollar amount for unreimbursed medical, dental, vision, orthodontia, and dependent care expenses. If you have predictable out-of-pocket expenses, you may want to consider enrolling in the FSA.

Depending on your plan, you have the option to join two separate FSA accounts:

An Unreimbursed Medical Account* can be used for eligible medical, dental, and vision expenses. Examples include:

- Office visit co-pays
- Deductibles
- Prescription eyeglasses or contact lenses
- Dental cleanings
- Orthodontia

*For a list of common medical, dental, and health-related expenses typically considered to be qualifying expenses, please refer to the list on the back of the Flexible Spending Account (FSA) Reimbursement Claim Form for Unreimbursed Medical Expenses in this booklet or go to benefits.paychex.com.

A Dependent Care Account can be used for custodial expenses for a claimed dependent. Examples include:

- Day care center or babysitter to allow you (and your spouse, if married) to work, actively look for work, or be a full-time student
- Custodial or elder care



Why Should I Participate in an FSA?

Tax Savings. FSA deductions come out of your paycheck before most withholding taxes are computed, reducing your taxable income and **increasing your take-home pay!**

Budgeting. Regular payroll deductions help you budget medical, dental, vision, orthodontia, and dependent care expenses.

Ease and Convenience. The Paychex Online Flexible Spending Account site is available 24 hours a day/7 days a week, and you can contact Paychex Employee Services at 877-244-1771 Monday through Friday from 8:00 a.m. to 8:00 p.m ET.

When Can I Enroll in FSA?

Open Enrollment

If you meet the plan's eligibility requirements outlined in the Summary Plan Description (SPD)*, you can enroll or change your annual election for the upcoming year during the open enrollment period using our website or automated phone system. The effective date for benefit plans elected during open enrollment is January 1 of the following year.

Sole proprietors, partners in a partnership, greater than two percent owners of an S-Corporation, and members of LLCs taxed as such, and their family members, are ineligible to participate in a Section 125 plan.

You do not need to re-enroll in the FSA plan each year. If you do not submit a change or a request to cease participation during open enrollment, the annual election amount currently on file will be used for the following plan year.

Note: The IRS maximum annual employee contribution for Unreimbursed Medical Expenses (UME) for 2015 is \$2,550. Please refer to the SPD* for your plan's maximum contribution as it may be different from this amount.

*You can view the SPD at benefits.paychex.com or request a copy from your employer.

Entry Date Enrollment

If you are a new employee who has met the eligibility requirements outlined in the SPD, you need to submit a paper enrollment form, which can be obtained from your employer or online. If you are eligible for enrollment, but do not enroll prior to your eligibility/effective deadline, you will not be eligible again until January of the following year unless a qualifying event occurs.

How Do I Know How Much to Contribute?

Use the Flexible Spending Account Deduction Worksheet in the back of this booklet to calculate your eligible expenses and determine the per-pay-period FSA deduction amount. You can also use our online calculator at www.paychex.com/print/fsa-calc.

Important: Be sure to consider the maximum amount your employer allows for unreimbursed medical expenses (refer to the SPD) and any amount he is contributing toward the plan. The maximum household deduction* allowed for dependent care expenses, per federal guidelines, is \$5,000.

*A "household" can be described as the total number of taxpayers (living as spouses as defined under federal law) who are filing tax returns either jointly or separately. The amount of dependent care assistance is limited to \$5,000 per tax year (\$2,500 for married individuals filing separate returns).

Enrolling

You can enroll in the FSA plan using one of the following options:

1. Online

- Log in to benefits.paychex.com and select **Flexible Spending Account**.
- If you have not already registered, select **Register for a New Account** and follow the prompts.

2. Phone

- Dial 877-244-1771 and follow the prompts.

How Do I Get Reimbursed?

Eligible Expenses

Medical expenses are eligible for reimbursement provided that they are to diagnose, treat, or prevent an existing medical condition, and you have not been reimbursed for them through any other benefits plan. Some items may require a prescription, doctor's note, or additional certification from a medical provider to show expenses are eligible.

For a list of common medical, dental, and health-related expenses typically considered to be qualifying expenses, please refer to the list on the back of the Flexible Spending Account (FSA) Reimbursement Claim Form for Unreimbursed Medical Expenses in this booklet or go to benefits.paychex.com.

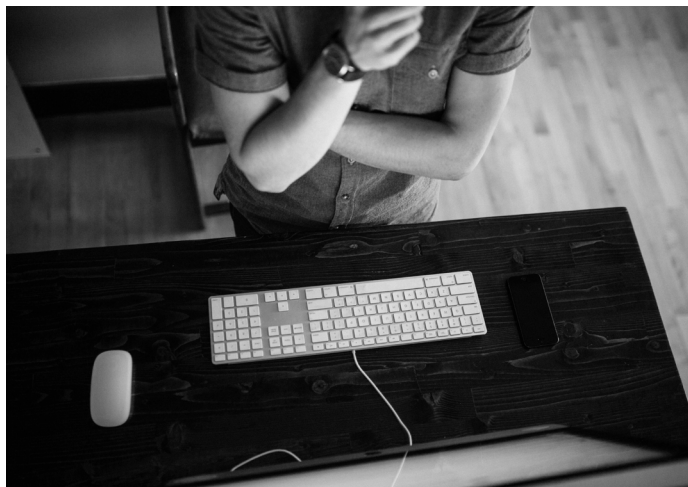
Submitting Claims

After you have paid for a medical or dependent care expense using out-of-pocket funds, submit a request for reimbursement with documentation to substantiate the eligibility of the purchase.

You can submit claims online and fax or mail written substantiation for each item to Paychex. Third-party receipts must include: the name of the service provider, date(s) of service, dollar amount of the service, and a description of the service provided. A prescription must be included with the receipt for over-the-counter medicine and drug purchases other than insulin.

If you submit a claim through the website, it will not be processed until all supporting documentation is received. The submission will be reviewed and, if it is approved, you will receive reimbursement from your FSA. Claims are processed within two business days of receipt. Please continue to check the status of the claim on the website for confirmation that the claim has been accepted and approved.

If your claim is on hold or denied, you will receive written notification explaining the reason for the hold or denial. You can access your claims status anytime at benefits.paychex.com or by calling 877-244-1771.



Orthodontia

For orthodontia reimbursement, you must provide a copy of an orthodontia contract (or a written statement from the orthodontist, Form FSA045) indicating the length of treatment and schedule of payments. This information is required since treatment of orthodontia is ongoing, and reimbursement of medical expenses prior to services being rendered is not permitted.

You will not be reimbursed in full if the orthodontia bill is paid up front. Once Paychex receives the contract, you must submit a claim form and itemized receipt from the service provider in order to be reimbursed. The claim form and receipt must match the amount listed on the payment schedule of the orthodontia contract.

Note: You can elect to submit only one claim form each plan year for the total amount of orthodontia care as opposed to monthly amounts. Services will be allocated over the length of the contract, and you will receive reimbursement as services are incurred.

Reimbursement Request Timeframes

You have up to 90 days ("closeout period") after the end of the plan year (December 31), or termination of your employment, to submit claims for reimbursement. Eligible expenses must be incurred during the plan year (up to and including your termination date) while you are an active participant.

Your employer may choose to offer one of the following options for your FSA plan.

- Your employer may offer a grace period up to and including March 15 of the following year to incur expenses that can be reimbursed from your prior year's account. This only applies if you were an active participant on the last day of the plan year (December 31) and have a balance remaining in your prior year's account. If a reimbursement received by March 31, 2016, is put "on hold" because we need additional documentation, you have until May 15, 2016, to submit the required documentation.
- Your employer may offer an option to carry over up to \$500 of unreimbursed medical expense funds from the current year to the following year. This allows you to incur expenses up to and including December 31 of the following year that can be reimbursed from your prior year's account. This only applies if you were an active participant on the last day of the plan year (December 31) and have a balance remaining in your prior year's account. If a reimbursement received by March 31, 2016, is put "on hold" because we need additional documentation, you have until May 15, 2016, to submit the required documentation.

Reimbursement requests will be processed in the order in which they are received. If your employer offers a grace period or \$500 carryover, submit reimbursement requests for services from the previous plan year before you submit claims for the current year to ensure that you receive the maximum benefit.

FSA Debit Card

You can use an FSA debit card to access your funds and pay for FSA-eligible items and services at a point-of-sale terminal rather than submitting a claim form for reimbursement.

You can also use your FSA debit card at www.paychex.com/fsastore-employee to purchase FSA-eligible products.

Depending on the items purchased, you may still need to submit documentation to validate the expense as eligible under the plan.

To stay up-to-date about vendor card acceptance and see the most current list of accepting merchants, refer to www.sig-is.org.

FSA Direct Deposit

FSA direct deposit allows you to receive medical and dependent care claim reimbursement through direct deposit to your bank account. Contact your employer to determine if this feature is offered.

Termination

If your employment is terminated, you will have 90 days to submit receipts for expenses incurred on or prior to your termination date. Additionally, you have 90 days from your termination date to submit documentation for any claims that were placed on hold or required substantiation prior to your termination date.

Forfeitures

All claims for services incurred on or before December 31 must be submitted by March 31 of the following calendar year. If unclaimed funds remain in your account after the claim filing and resolution deadlines, they are forfeited to the plan and cannot be reimbursed.

If your employer offers the grace period, you will have until March 15, 2016, to incur expenses; however, you must submit requests for reimbursement by March 31. If unclaimed funds remain in your account after this time, they are forfeited to the plan and cannot be reimbursed.

If your employer offers the carryover option, you can carry over up to \$500 of your prior year's remaining account balance; however, any amounts in excess of the plan's carryover limit will be forfeited to the plan and cannot be reimbursed.

Please contact your plan administrator to determine whether your company offers the grace period or carryover option.

Changing Your Election

Your FSA election cannot be changed during the plan year unless you experience a qualifying event. Qualifying events include:

- Marriage* or divorce
- Death of your spouse* or dependent
- Birth or adoption of a child
- Termination or commencement of spouse's* employment
- Change in employment status from part-time to full-time or full-time to part-time for you or your spouse*
- Unpaid leave of absence by you or your spouse*
- Eligibility or ineligibility of Medicare/Medicaid
- Cost-motivated dependent care changes, such as cost increases/decreases (for example, relative becomes available to watch child)

*As defined under federal law.

Please refer to the SPD for more information about changing your deduction. If a qualifying event has occurred, you must submit supporting documentation and enrollment modifications to your employer within 30 days of the event.

In addition, under federal regulations you cannot move money between your medical and dependent care accounts.

What Tools Can I Use to Manage My FSA?

Visit the Paychex Online Flexible Spending Account site at benefits.paychex.com or use the Paychex mobile app at any time to:

- access claim, payment, and balance information
- review account balances and elections
- request an SPD or FSA-related forms

You can also call the automated Paychex Employee Services phone line at 877-244-1771.



Claims Submission Guide

1. Login to **https://benefits.paychex.com**, and select Paychex Benefit Account.
2. You will be brought to your Home page where you can see a quick view of your plan information and available balance(s) for the plan year.

3. Click on File A Claim.

4. Fill out all the information to submit the claim.
 - a. Account Type will be a drop down of Medical or Dependent Care depending on what the plan allows and/or if dependents are listed on the account.
 - b. You cannot file a claim without having a valid receipt.
 - c. Receipt upload must be .jpg, .gif or .pdf file type and cannot be larger than 2MB.

5. Click on Add Claim. This will bring you to your Claims Basket where you can either add additional claims or complete the submission process.

Note: If you log out of your PBA account at any time without submitting the claims in the Claims Basket, you will need to reenter your claims. The Claims Basket does not save in-between logins.

- To submit, simply confirm that you've read the Terms and Conditions, and then click Submit Claim.

Claim Confirmation

Claim Successfully Submitted
You may print your [Claim Confirmation Form](#) as a record of your submission.

We will process your reimbursement within two business days following the date we receive the required documentation from you.

Account	Claim Details	Receipt Status
FSA (01/01/2015 - 12/31/2015)	\$52.30 on 2/1/2015 From Bright Smiles for SCOTT BROWN Payable to SCOTT BROWN	Uploaded Upload another Receipt

- You may also access a copy of the Claims confirmation form.

You have successfully filed the claim(s) listed below.

We will process your reimbursement within two business days following the date we receive the required documentation from you.

Claim Number	Plan	Date of Service	Provider / Merchant	Recipient	Receipt Amount	Mileage Amount	Receipt Status
S435SS150311P0000101	FSA	2/1/2015	Bright Smiles	SCOTT BROWN	\$50.00	\$2.30	Uploaded
Totals:					\$50.00	\$2.30	

Remember, regardless of which (if any) receipts you are required to submit, you are responsible for retaining a copy of all receipts for three years in the event you or your Pre-tax Account plan are audited by the IRS.

You can check the status of a claim any time afterwards by accessing your Dashboard.

PAYCHEX ONLINE

Last Login: 2/18/2015 - Online

Home Accounts Profile Statements & Notifications Tools & Support Dashboard

Dashboard View Non-Healthcare

Expense Summary	Total Healthcare Expenses	Total Paid Expenses	Total Unpaid Expenses
	\$180.75	\$71.15	\$109.60

Total Eligible to Submit: **\$0.00**

Date	Expense	Recipient/Patient	Merchant/Provider	Submitted Amount	Status
02/17/2015	Pharmacy	Marcia Brown	Doctor	\$52.30	Unpaid
02/01/2015	Pharmacy	SCOTT BROWN	-	\$26.15	Unpaid
02/01/2015	Dental	SCOTT BROWN	Bright Smiles	\$52.30	Unpaid

Payment Details

Claim Number: S435SS150311P0000101 Date(s) of Service: 2/1/2015
 Account: FSA Requested On: 3/11/2015
 Expense Category: Dental Pending: \$52.30
 Source: Online
 Receipt Status: Uploaded
 Upload Receipt(s) View Receipt(s)

Date	Expense	Recipient/Patient	Submitted Amount	Status
01/20/2015	Medical	SCOTT BROWN	\$50.00	Unpaid

Online Enrollment Guide

These steps will help you navigate our Employee Website during Open Enrollment.

- Login to your Paychex Benefit Account at <https://benefits.paychex.com>, and select Paychex Benefit Account.
- When Open Enrollment is available, you will see the option to Enroll Now.

PAYCHEX ONLINE

Home Accounts Profile Statements & Notifications Tools & Support Dashboard

I Want To...
[Enroll Now](#)
[Manage My Expenses](#)
 Available Balance: No active plans available.
[Enroll Now](#)

Don't Forget!
It's Annual Enrollment Time
[Enroll Now](#)

Message Center
[Download Mobile App](#)
[Quick View](#)
 No views available.

Contact Us - Call Paychex Benefit Account Services at (877) 244-1771, Toll Free at (877) 244-1771 or Email us at PaychexBenefitAccount@paychex.com

- By clicking Enroll Now, you'll see the available plans that your company offers for the plan year. Some basic plan information will display, but if you need specific plan details, please ask your employer for a copy of the Summary Plan Description (SPD). The site information does not replace the SPD. Click on Begin Your Enrollment Now to continue.

Enrollment

Are you ready to enroll? [Begin Your Enrollment Now](#)

Enrolling in a Pre-Tax Benefit plan allows you to save Federal, State, Social Security and Medicare taxes on dollars you put into the plan. You could save approximately 30% on every plan dollar you spend, depending on your tax bracket.

Review your available plans to find out how to best use these programs. To learn more about the benefits offered, click on the appropriate Plan Description link below.

FSA [Plan Description](#)
 A Medical Flexible Spending Account (FSA) allows the employee to set aside pretax dollars to pay for medical expenses that are not paid by insurance, the employer, or reimbursed by any other source. The annual election maximum is based on the plan's design. The annual election that the employee determines is irrevocable once the employer's open enrollment period is over unless the employee experiences a status change. The election must be requested for reimbursement for services within the plan year and/or while actively participating in the plan.

Dependent Care [Plan Description](#)
 A Dependent Care Spending Account allows the employee to set aside pretax dollars to pay for day care expenses for children under the age of 13 or for adult day care for a disabled spouse or other disabled dependent. The IRS rules about what constitutes eligible dependent care expenses apply. A maximum of \$5,000 can be set aside in a Dependent Care Spending Account for each plan year for married couples filing joint tax returns and single head of household tax returns. Married couples filing separate returns are allowed to claim a maximum of \$2,500 each.

Questions?
 Contact Paychex Benefit Account Services at: (877) 244-1771 Or toll free at: (877) 244-1771 or PaychexBenefitAccount@paychex.com

- You will then be asked to verify your profile information.

Participant Profile

steps: 1 2 3 4 5 6

First Name:
 Middle Initial:
 Last Name:
 Participant Account ID:
 Country:
 Address Line 1:
 Address Line 2:
 City:
 State:
 Zip Code:
 Home Phone:
 Birth Date: (mm/dd/yyyy)
 Gender:
 Marital Status:
 Email Address: jpliley123@gmx.com

By providing an email address, you will receive communications electronically about your Flexible Spending Account. Your email address will not be shared or used for any other purpose. Please note that this will update your e-mail for the FSA plan only. To change your e-mail address with additional Paychex products, please login to <https://benefits.paychex.com>, Click on Change my Profile from the Left Navigation Bar and enter updated e-mail address.

Do you have any dependents? ☒ Yes ☐ No

* = required field

5. If you have or would like a Dependent Care plan, you can add a dependent by clicking Yes to "Do you have any dependents" and adding the dependent information.

Dependents

steps: 1 2 3 4 5 6

First Name: Testing
 Middle Initial: A
 Last Name: Dependent
 Birth Date: 1/7/2003 (mm/dd/yyyy)
 Gender: ☐ Female ☒ Male
 Full Time Student: ☐ Yes ☒ No
 Relationship: Dependent

* = required field

6. You must then approve the plan rules. Again this is not a substitute for the SPD, so please see your employer for additional information.

Plan Rules

steps: 1 2 3 4 5 6

It is important to be aware of some of the basic rules of these accounts before you enroll. Make sure you keep these in mind when you are making your elections. We also encourage you to review the Summary Plan Description for more detailed rules regarding these Pre-tax Accounts.

FSA

I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year, and that I cannot change or revoke my election unless I experience a status change in accordance with Internal Revenue Code Section 125 and submit the change within 30 days of the status change. I am aware of the plan's forfeiture provision, and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. I authorize the release of any information necessary for Flexible Benefits. I hereby certify that the reimbursement requests I will be submitting are IRS-eligible expenses, and that I will not be nor have I been previously reimbursed for these expenses; nor am I seeking reimbursement for these expenses from insurance or any other source. I also understand that Paychex, nor its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement.

I understand that checking this box indicates my acknowledgement of these plan rules, and that I have the option to enroll or waived enrollment in this plan.

☒ I have read and understand the [FSA rules](#).

Dependent Care

I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year, and that I cannot change or revoke my election unless I experience a status change in accordance with Internal Revenue Code Section 125 and submit the change within 30 days of the status change. I am aware of the plan's forfeiture provision, and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. I authorize the release of any information necessary for Flexible Benefits. I hereby certify that the reimbursement requests I will be submitting are IRS-eligible expenses, and that I will not be nor have I been previously reimbursed for these expenses; nor am I seeking reimbursement for these expenses from insurance or any other source.

I understand that checking this box indicates my acknowledgement of these plan rules, and that I have the option to enroll or waived enrollment in this plan.

☒ I have read and understand the [Dependent Care rules](#).

7. After clicking Continue, you will then be asked for your election amount(s) for the plans offered. Use www.paychex.com/print/fsa-calc if you need help calculating what you should contribute for the year.

Elections

steps: 1 2 3 4 5 6

Enter your actual elections in the field provided. To calculate the total elections and tax savings, select the calculate button. If you choose to not enroll in a plan leave the field blank.

	Company Contribution	Your Election	Max Employee Election
FSA	\$500.00	<input type="text"/> 1500.00	\$2,550.00
Dependent Care		<input type="text"/> 3000	\$5,000.00
Total election for the year:		\$4,500.00	
Total tax savings for the year:		\$1,350.00	

* Tax savings estimate is based on a 30% tax rate. True tax savings will be based on your individual circumstances.

8. You will also be asked to select your secondary reimbursement method. Select check or direct deposit. Direct deposit instructions are shown here.

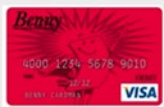
Payment Method

steps: 1 2 3 4 5 6

Select the method in which you would like to be reimbursed.

☒ Debit Card

The Debit Card may be used toward qualified purchases at point of sale. Certain purchases may be automatically approved, but many may require substantiation to ensure the expense is qualified per IRS regulations.



If you choose to be reimbursed using the Debit Card, please answer the questions below.


1) What alternate reimbursement method would you like to use for the reimbursement of claims that are filed online?

☐ Check
☒ Direct Deposit

Setup Direct Deposit

steps: 1 2 3 4 5 6

Routing Number: 021000021
 Account Number: 123456789
 Account Type: Checking
 Account Nickname:
 Bank Name: JPMORGAN CHASE BANK
 Street Address: 3RD FLOOR
 City: TAMPA
 State: Florida
 Zip Code: 33610-0000



* = required

9. Once completed you are then ready to verify your enrollment, click submit if everything appears correctly. You can change/update this amount until the close of the Open Enrollment period.

Enrollment Verification

steps: 1 2 3 4 5 6

You must click submit at the bottom of this page to complete your enrollment.

Profile

Edit Information

Name: [REDACTED]
Address: [REDACTED]
Home Phone: [REDACTED]
Birth Date: [REDACTED]
Gender: [REDACTED]
Marital Status: [REDACTED]
Email Address: jplilley123@gmx.com
Do you have any dependents? Yes

Dependents

Edit Information

Full Name	Birth Date	Gender	Full Time Student	Relationship
Testing Dependent	1/7/2003	Male	No	Dependent

Enrollment Elections

Edit Information

	Employee Contribution	Company Contribution
FSA	\$1,500.00	\$500.00
Dependent Care	\$3,000.00	
Total Election for the year:		\$4,500.00

Method of Reimbursement

Edit Information

You have chosen **Debit Card** as your method of payment.
Your alternate reimbursement method is Direct Deposit.
Separate debit cards will be issued to the following dependents:
No dependent debit cards issued

Submit Cancel

10. Your confirmation message will display.

Enrollment Confirmation

Please print this page for your records.

Congratulations, you have successfully enrolled in the following Benefit Plans. Please Note: Employer Contribution values displayed are at the discretion of your Employer and the value could change. If you have questions on an Employer Contribution, please speak to your Company's Plan Administrator.

Plan	Company Contribution	Employee Contribution
FSA	\$500.00	\$1,500.00
Dependent Care		\$3,000.00

You have elected Debit Card as your reimbursement option. Your alternate reimbursement method is Direct Deposit.

You may begin filing claims for eligible expenses on 4/15/2015. All claims must be filed for expenses incurred while you are a participant, within the plan year 4/15/2015 - 12/31/2015

You will receive a confirmation email with instructions on how to file a claim, check your account balance, and obtain additional information about your pre-tax benefit plans. You can also view this information now by downloading the [Next Steps](#) document.

Print

This is not an enrollment form. This worksheet is intended to assist you with the enrollment process by helping you calculate your applicable expenses and how much money would be in an FSA deduction each pay period.

Note: Expenses incurred by or on behalf of a domestic partner and/or a domestic partner's child(ren) are not reimbursable.

Medical/Dental/Vision Reimbursement Account**Annual Medical Expenses, such as:**

Deductibles and co-pays	\$ _____
Routine physical exams	\$ _____
Prescriptions	\$ _____
Chiropractic care	\$ _____
Other	\$ _____

Annual Dental Expenses, such as:

Deductibles and co-pays	\$ _____
Routine check-ups	\$ _____
Orthodontia	\$ _____
Other	\$ _____

Annual Vision Care Expenses, such as:

Exams	\$ _____
Eyeglasses	\$ _____
Contact lenses, solutions, cleaners	\$ _____
Other	\$ _____

Total Estimated**Medical/Dental/Vision Expenses**

\$ _____	÷	_____	=	\$ _____
Annual Amount (cannot exceed company max.)		# of Pay Periods*		Per Pay Period

Dependent Care Reimbursement Account**Annual Dependent Care Expenses:**

Payment to a dependent care facility or individual	\$ _____
Payment to other care providers	\$ _____

Total Estimated**Dependent Care Expenses**

\$ _____	÷	_____	=	\$ _____
Annual Amount (cannot exceed \$5,000 IRS max.)		# of Pay Periods*		Per Pay Period

Total Per-Pay-Period Reduction

(Add total estimated medical/dental/vision expenses and total estimated dependent care expenses.)

\$ _____
Total Per Pay Period

*Weekly, 52 pay periods • Biweekly, 26 pay periods • Semimonthly, 24 pay periods • Monthly, 12 pay periods



Enrollment Form

Paychex Benefit Account Flexible Spending Account

SECTION 1 - EMPLOYEE INFORMATION (print)

Office/Client Number _____

Company Name _____ Employee Telephone Number (____) _____ - _____

Employee Name _____ Social Security Number _____

Address _____ City _____ State _____ ZIP Code _____

Email Address _____

SECTION 2 - ENROLLMENT OPTIONS (select one)☐ **New Enrollment or Annual Enrollment Changes**

Date of Hire ____/____/____

Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met.

Annual enrollment changes will be effective on the first payroll following January 1.

☐ **Change In Status**

Date of Event ____/____/____

Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to the Employer within 30 days of the event.

- ☐ Dependent care cost provider changes
- ☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements
- ☐ Birth/Death of spouse or dependent, adoption or placement for adoption
- ☐ Spouse's employment commenced/terminated
- ☐ Status change from full-time to part-time or vice versa by employee or spouse*
- ☐ Eligibility or Ineligibility of Medicare/Medicaid
- ☐ Change from salaried to hourly or vice versa*
- ☐ Marriage/Divorce/Legal Separation
- ☐ Unpaid leave of absence by employee or spouse
- ☐ Return from unpaid leave of absence by employee or spouse

* These changes are allowable only if eligibility is affected.

SECTION 3 - ENROLLMENT ELECTION

To calculate your per-pay-period deduction, divide your annual amount by the number of pay periods remaining in the plan year. In accordance with IRS regulations, Employee contributions to the medical FSA cannot exceed the lesser of the company's plan maximum or \$2,550.00. Employers may contribute an additional amount which will be added to the Employee's contribution amount to equal the total annual election amount.

☐ Annual Medical/Dental/Vision Election \$ _____ (Medical FSA)
Cannot Exceed Company Maximum

☐ Annual Dependent Care Election \$ _____ (DCA)
Maximum \$5,000.00

DCA is issued for custodial care of a dependent, not for medical expenses of a dependent.

☐ Discontinue my Enrollment in Medical/Dental/Vision Care

☐ Discontinue my Enrollment in Dependent Care

To discontinue enrollment, a change in status reason must be selected.

Notes:

If you are enrolled only in DCA, a debit card will not be issued. Dependent information is required to submit claims for services incurred by your dependent. To update this information please visit <https://benefits.paychex.com>, click **Add Dependent** under the Profile section of the Paychex Benefit Account page.

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year ____/____/____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. I cannot change or revoke this election at any date prior to the next plan year unless I experience a change in status (also referred to as a qualifying event). If, during my next enrollment period, I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election as set forth in this election form for the next plan year. As a participant, I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

Reduction of Pay

- ❖ I understand that my pay will be reduced each pay period by the amount of my required contribution for the benefit option(s) I have elected until this agreement is amended or terminated. The reduction in my pay under this agreement will be in addition to any reductions under other agreements or benefit plans.
- ❖ I understand that my pay reduction will be automatically adjusted if my required contributions change while this agreement is in effect and that the plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.

Reimbursements

- ❖ I understand that my Employer will hold my contributions for payment of eligible expenses incurred within the Plan Year and that reimbursement will be available only for qualifying expenses.

- ❖ I agree to notify my Employer if I believe that any expense for which I have received reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer for any liability Employer may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- ❖ I understand that I will have a closeout period after the end of the plan year during which I can submit eligible expenses incurred during the plan year (and grace period if applicable). I understand that I will forfeit any remaining balances, including those in excess of any allowable carryover amount; I have at the end of the closeout period for which I have no eligible expenses to submit.

FSA with an HSA

- ❖ If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.

Employee Signature _____ Date _____/_____/_____

Account Information is available at <https://benefits.paychex.com> or on the FSA Information Line by dialing 877-244-1771.

MAIL or FAX to Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: 585-389-7349

FAX: 585-389-7003

Submit or view claims **ONLINE:** <https://benefits.paychex.com>

Paychex Employee Services: 877-244-1771, automated system available 24/7,
Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

FOR OFFICE USE ONLY

Docket # _____



Paychex Benefit Account (PBA) Reimbursement Claim Unreimbursed Medical Expenses

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (____) _____ - _____

Email Address _____

**** PLEASE DO NOT USE THIS FORM TO SUBMIT DEBIT CARD SUBSTANTIATION ****

Visit <https://benefits.paychex.com> at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ Enclose copies of all itemized bills, receipts, or Explanation of Benefits (EOB) from your provider or a copy of your orthodontia services contract, if applicable. **We recommend using the FSA Orthodontia Claim Form (FSA045) to submit for Orthodontia services.** Use blue or black ink only to identify FSA items on receipts. Do not use highlighter. **Copies of personal checks, cancelled checks, or credit card receipts are not valid for verification of service.**

- ☐ Verify that bills and receipts contain:

- date of service
- description of service
- cost of service
- provider's name
- provider's address

**** OVER THE COUNTER MEDICATIONS WILL REQUIRE A PRESCRIPTION FROM YOUR DOCTOR ****

- ☐ If you are currently funding a Health Savings Account (HSA) in addition to your FSA, your FSA is a limited purpose FSA and may only be used to pay for vision, dental, and preventative medical expenses.
- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Name of Service Recipient*	Relationship to Employee	Service Date(s)	Service Description	Service Provider	Amount
Sample John Doe	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent	07/07/07	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy	Dr. Jones	\$521.43
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy		\$
TOTAL					\$

If you have more claims, please complete additional Reimbursement Claim forms.

*All Dependents must be entered online prior to claims submission at <https://benefits.paychex.com>. Click **Add Dependent** from the Profile Section under Paychex Benefit Account.

CLAIM INFORMATION

I certify that the information here is true and correct; that the expenses incurred were for myself, my spouse as defined by federal law, or my eligible dependents; and that these expenses are not reimbursable under any other health plan coverage.

Employee Signature _____ Date _____ / _____ / _____

PBA016a 03/15

Paychex FSA Reimbursement Expenses-at-a-Glance

Some items below may require a prescription, doctor's note or additional certification from a medical provider to show expenses are reimbursable under a health FSA to the extent that they are to diagnose, treat, or prevent an existing medical condition. Expenses incurred by or on behalf of a domestic partner and/or a domestic partner's child(ren) are not reimbursable.

HEALTH CARE EXPENSE EXAMPLES THAT ARE ELIGIBLE:

A.E.D. for home use	Diagnostic/screening services	Oxygen equipment
Alcoholism treatment	Drug addiction treatment facilities	Physical exam
Ambulance services	Fertility treatments	Podiatrist
Astigmatic keratotomy	Guide dog/care	Prescription medication
Bandages	Hearing aids/batteries/repairs	Prescription sunglasses
Blood pressure monitors	Hospital services	Prosthesis (artificial limbs)
Braille books and magazines (to extent prices exceed the prices of regular books and magazines)	Hot/cold packs and heating pads	Rental of medical equipment
Car equipped for disabled person (to extent price exceeds the price of regular car)	Insulin	Rewetting eye drops
Clinic charges	Laboratory fees	Shipping costs (medical care items)
Contact lenses/solution	Lasik eye surgery/radial keratotomy	Smoking cessation prescriptions
Co-pays and deductibles	Lead-based paint removal to treat lead poisoning	Special education for physically or mentally disabled family member
Crutches	Lodging for medical care	Sperm storage fees (temporary)
Dental retainer	Medical monitoring/testing devices	Sterilization
Dentist's fees (not cosmetic)	Medical records fees	Surgery/treatments
Denture adhesives	Midwife expense (medical care)	Telephone (for the deaf)
Dentures/dental implants/partials	Nurses' expenses and board	Thermometer
Doctor's fees (not cosmetic procedures)	Nursing care	Transplants
Eye exam/prescribed eyeglasses	Obstetrical services	Transportation for essential care
Eyeglass repairs for Rx glasses	Orthodontia (contract required)	Vasectomies (and reversals)
Diabetic supplies and test strips	Osteopath, licensed	Wheelchairs
	Ovulation monitor	X-ray fees

OVER-THE-COUNTER MEDICINE/DRUG EXAMPLES THAT ARE ELIGIBLE WITH A DOCTOR'S PRESCRIPTION*:

*Over-the-counter (OTC) medicines and drugs (other than insulin) are no longer eligible for reimbursement under a medical flexible spending account **unless** prescribed by a medical practitioner.

Acne medications	Cough medications/drops/syrups	Pain relievers/analgesics
Allergy medications	Decongestants	Spermicides
Allergy nose sprays	Digestive aids	Toothache/teething pain relievers
Antacids	First aid kits/supplies	Vitamins/minerals
Antifungal medications	Gingivitis mouthwash/treatments	Wart removal treatments
Anti-gas treatments	Hemorrhoid creams/suppositories	Weight loss/dietary supplements
Antihistamines	Herbal supplements	Yeast infection creams
Anti-itch treatments	Lactose intolerance pills	
Antiseptic first aid sprays	Laxatives	
Calcium supplements	Medicated rubs/muscle creams	
Cold medications	Menstrual cycle medications	
Contraceptives	Motion sickness medications	

HEALTH CARE EXPENSE EXAMPLES THAT ARE NOT ELIGIBLE:

Clip-on eyeglasses	Insurance premiums	Soaps
Cosmetic procedures/products	Marital therapy	Teeth whitening products
Dental bleaching	Medications imported from outside U.S.	Toiletries
Dental floss	Mouthwash	Toothbrushes
Deodorants	Remedial reading classes	Toothpaste
Diaper service	Shampoo	Vitamins used for general health
Funeral expenses	Skin moisturizers/lotions	Warranties for eyeglasses
Illegal treatments or drugs		

DEFINITION:

An eligible dependent for Dependent Care Assistance is:

- Any dependent who has not attained 13 years of age and is your dependent under federal income tax rules. (If your child turns 13 during the year, you can stop your contribution at that time.)
- Your mentally or physically impaired spouse or a dependent incapable of caring for himself or herself (for example, an invalid parent).

The dependent must spend at least eight hours per day in your home and have the same principal place of residence as you, the taxpayer, for more than one half of the taxable year. Expenses incurred for, or on behalf of, a domestic partner's child(ren) are not reimbursable.

DEPENDENT CARE EXPENSES THAT ARE ELIGIBLE**:

- Services provided inside or outside your home, but not by your minor child or dependent
- Services provided by a qualified day care facility that cares for six or more individuals at the same time and complies with federal, state, and local laws
- Services incurred to enable you, or you and your spouse, to be employed, in search of employment, or full-time students
- Services for the custodial care of the dependent, not for education or meals
- Child care centers
- Family day care providers
- Babysitters
- Nursery schools
- Caregivers for a disabled dependent or spouse who lives with you
- Household services, provided that a portion of these expenses are for a qualifying dependent and are incurred to ensure maintenance of the dependent's well-being

**Amount that can be reimbursed is not greater than \$5,000, your earned income, or your spouse's earned income, whichever is lower.

DEPENDENT CARE EXPENSES THAT ARE NOT ELIGIBLE:

- Dependent care provided to one of your dependents by a family member under the age of 19 who will be claimed as your dependent for tax purposes
- Expenses for food and clothing
- Education expenses, kindergarten and beyond
- Health care expenses for your dependents
- Overnight camps
- Transportation

A more extensive listing of eligible expenses is available at <https://benefits.paychex.com>.

Paychex Employee Services: 877-244-1771, automated system available 24/7, representatives available Mon. – Fri. 8:00 a.m. – 8:00 p.m. ET

The Internal Revenue Service considers these expenses deductible and eligible for reimbursement through your FSA plan if they are to diagnose, treat, or prevent an existing condition and if you have not been reimbursed for them through any other benefit plan.

FSA011 08/13

FAX: 585-389-7003

Submit or view claims **ONLINE:** <https://benefits.paychex.com>

**Paychex Employee Services: 877-244-1771, automated system available 24/7,
Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET**

FOR OFFICE USE ONLY

Docket # _____



Flexible Spending Account (FSA) Reimbursement Claim Dependent Care Allowance

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (____) _____ - _____

E-mail Address _____

Visit <https://benefits.paychex.com> at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ **Complete the table below and** enclose copies of all itemized bills and/or receipts from your provider. Use blue or black ink only to identify FSA items on receipts. **Do not use highlighter. We will not accept copies of personal checks, cancelled checks, or credit card receipts as verification of service.**
- ☐ Verify that bills and receipts contain:
 - start and end dates of service
 - provider's name
 - service recipient's age (if dependent under age 13)
 - cost of service
 - service recipient's name
- ☐ **For your convenience, in lieu of an itemized receipt, you may have your Dependent Care Provider sign the Certification From Provider section below.** Otherwise, an itemized receipt for your dependent care expenses will be required.
- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Claim	Name of Service Recipient	Age of Service Recipient	Date of Service Start Date	Date of Service End Date	Service Provider	Amount
SAMPLE	Baby Doe	1 year	10/1/2011	10/31/2011	Ms. Smith	\$325.00
01						\$
02						\$
03						\$
04						\$
05						\$
TOTAL						\$

Note: Dependent Care Claims will be reimbursed up to the year-to-date contributions made to your account at the time of submission. If you submit for dates of service in the future or for amounts above your current contribution balance, reimbursement will automatically be issued once the date has passed and/or additional contributions have been made for this plan year.

If you have more claims, please complete additional Reimbursement Claim forms.

CERTIFICATION FROM PROVIDER

We certify that we are providing Dependent Care Services for the service recipients and service dates listed above for the amounts indicated.

Dependent Care Service is care of, or related household services for, a dependent under age 13 or a dependent or spouse that is incapable of self care, and is not for school tuition. Before/after school care is a qualified expense and should be itemized to break out from cost of school tuition if applicable. Expenses incurred by or on behalf of a domestic partner's child are not reimbursable.

Name of Dependent Care Provider _____

Signature of Dependent Care Provider _____ Date ____/____/____

CLAIM INFORMATION

I incurred the expenses listed above for reimbursement on behalf of my eligible dependent or spouse for reimbursable items under Section 125 of the Internal Revenue Code.

Employee Signature _____ Date ____/____/____

FAX: 585-389-7003

Paychex Employee Services: 877-244-1771,
automated system available 24/7, representatives
available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

Submit or view claims **ONLINE:** <https://benefits.paychex.com>

MAIL: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000



Flexible Spending Account (FSA) Reimbursement Claim Orthodontia Services

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number (last 4 digits) _____ Employee Telephone Number (____) _____ - _____

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

HOW WOULD YOU LIKE TO BE REIMBURSED?

Select one:

- ☐ **DEBIT CARD** – I will be using my **FSA Debit Card** and do **not** want to be reimbursed by monthly check or direct deposit.

Note: By selecting this option, Paychex will place your payment details on file. Your card can then be used for the initial fee(s) and to make each monthly payment for the amount indicated in the certification details below. Please note, the FSA Debit Card may NOT be used to *prepay* for monthly orthodontia services.

OR

- ☐ **AUTOMATIC CLAIM PAYMENTS** – I want to receive reimbursement of initial fee, records fees, and monthly payments for my orthodontia automatically for the duration of orthodontia services provided in the certification below.

Notes:

- If your monthly payment details change, promptly submit an updated Paychex FSA045 Orthodontia Claim Form.
- Per IRS guidelines, medical services are reimbursed under an FSA as services are incurred. Paychex will process your orthodontia claim on a monthly basis for the duration of your orthodontia services. If you choose to pay the full contract up front to the provider, this will **not** allow your FSA plan to reimburse you the full amount upon submission. The initial fee and records fee may be reimbursed when services begin. Payment date will determine which plan year funds are reimbursed from.

- ☐ **SUBMIT INDIVIDUAL CLAIMS** – I want to receive reimbursements for my orthodontia services only when I submit a claim for them. *(Paychex will record your orthodontia contract details and process your orthodontia claims within two business days, only for the amounts requested.)*

CLAIM AUTHORIZATION

Please ensure that the Certification from Orthodontia Provider is completed in full and signed by the provider.

I certify that the information herein is true and correct; that the expenses incurred were for myself, spouse, or dependents; that these expenses are not reimbursable under any other health plan coverage; and that these expenses are eligible under Section 125 of the Internal Revenue Code.

Employee Signature _____ Date ____/____/____

CERTIFICATION FROM ORTHODONTIA PROVIDER (to be completed by provider)

Name of Orthodontia Provider _____

We certify that we are providing orthodontia services for _____
Patient's Name

Note: Your payment details must be completed in full and mathematically correct for your claim to be paid out.

Contract Information

Start Date _____ (Date of First Monthly Payment)

_____ Total Dollar Amount of Contract

- _____ Initial Fee (Date Paid _____)

- _____ Discount (if applicable)

- Records Fee (if applicable) (Date Paid _____)

- _____ Insurance (if applicable)

= _____ Remaining Balance ÷ _____ = _____
total months of service qualified monthly reimbursable amount

Example:

\$2,900 Total Dollar Amount of Contract
- \$500 Initial Fee
- \$0 Discount
- \$0 Records Fee
- \$0 Insurance
= \$2,400 Remaining Balance ÷ 24 = \$100

Signature of Orthodontia Provider _____ Date ____/____/____



*Flexible Spending Account
Direct Deposit
Enrollment Form for FSA Claims*

Use this form to enroll in the Direct Deposit service for your Flexible Spending Account (FSA). With Direct Deposit, your FSA reimbursements will be deposited electronically into your bank account rather than sent to you as paper checks. Use this form if you are enrolling for the first time in Direct Deposit or if you are changing the account that will receive your reimbursements. All direct deposits will be processed within three business days.

Instructions:

- ☐ Complete the Required Information section.
- ☐ Complete the Direct Deposit Information section.
- ☐ **Sign and date the bottom of the form.**
- ☐ Make a copy of this form and retain for your records.
- ☐ Return this form and supporting documentation to:

Fax 585-389-7983

Mail Paychex, Inc.
Attn: FSA Claims
1175 John Street
West Henrietta, NY 14586

Required Information

PLEASE PRINT

Name _____

Social Security No. (last 4 digits) _____

Address _____

E-mail Address _____

Employer Name _____

☐ New Account

☐ Change Account

Direct Deposit Information

I authorize my employer to deposit my FSA reimbursements to the following bank account (select one):

- ☐ Checking Account Number _____
- ☐ Savings Account Number _____
- ☐ Paycard Account Number _____

Attach one of the following (select one) and indicate the name of the bank.

☐ Voided check (deposit slips are not accepted)

☐ Bank letter or specification sheet
(See your local bank representative.)

Bank Name _____

Attach a voided check here.

IMPORTANT: A voided check, bank letter, or specification sheet must be attached.

Authorization

SIGNATURE Date ____/____/____

Paychex Use Only

Entered by _____

Approved by _____

Date ____/____/____

Client BIS ID _____

For questions about completing this form, call Paychex Employee Services at 877-244-1771.

FSA005 06/14



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benefits.paychex.com

Paychex Employee Services
877-244-1771