VitaFlex
Medical and Dependent Care Reimbursement Plan
Election Form – 2007 Plan Year

Employee Data

Employer Name: **Fremont Union High School District - Monthly**	
Employee Name:	
Social Security Number:	Date of Hire:
Mailing Address:	
City, State Zip Code:	
Daytime Phone Number:	Evening Phone:
Email Address:	

Election and Coverage Information

Type of Election: ☐ New Employee ☐ Open Enrollment

Method of Receiving Explanation of Benefits: ☐ E-mail (with pdf attached) ☐ U.S. Mail ☐ E-mail Notice (with web link to secure site)

Current Health Coverages (Check all that Apply)

Medical: ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ HSA Carrier: ________________________

Dental: ☐ DMO ☐ PPO Carrier: _________________ **Vision:** ☐ Carrier: ___________________

Reimbursement Account Participation Request

Please indicate desired participation for the current Plan Year. This election may not be changed during the Plan Year unless a qualified Status Change occurs.

Medical Expenses

Plan Year Election: $_____________

Plan Year Maximum: $4,800.00

Per Paycheck Minimum: $0.00

This election is for eligible medical expenses for yourself and/or your dependents. Premium contributions should not be included in this election.

Dependent Care Expenses

Plan Year Election: $_____________

Plan Year Maximum: $5,000.00

Plan Year Minimum: $0.00

This election is for eligible dependent care expenses (daycare, childcare, or elder care) for your dependents. This election should not be used for medical expenses for your dependents.

Signature

I have read and understand the VitaFlex Medical and Dependent Care Reimbursement Plan guidelines as outlined in the Employee Guide and the SPD and I understand the restrictions that apply to eligible expense reimbursement requests. I understand that if I am covered under an HSA plan, only dental and vision expenses are eligible under the medical FSA and I will restrict my submitted claims to such dental and vision expenses. I understand that claims adjudication under this plan may require disclosure of Protected Health Information as defined under HIPAA. HIPAA compliance procedures are outlined in the Vita Privacy Notice, which will accompany the Claim Kit or which may be found at www.vitacompanies.com/privacy.asp. *Further, I understand that the above salary reduction request which will be allocated to my Reimbursement Account will be forfeited according to current plan provisions and tax laws if I do not incur and appropriately submit any eligible expenses within the Plan Year.* To the extent that I receive funds from the FSA Plan via reimbursement or via utilizing a debit card (if applicable) for any expense that is not fully documented within the prescribed time period or which is found to be an ineligible expense under the plan, I understand that I owe reimbursement to the FSA Plan for these funds immediately upon confirmation of the expense being ineligible. Further, I authorize my employer to deduct any monies that I owe to the plan directly from my paycheck on an after-tax basis to re-pay such expense to the plan. I certify the above information to be true and that the dependents that I intend to claim expense reimbursements for are legally dependent on me for their support as defined by current tax law. I agree to have my compensation reduced by the amounts indicated above. I understand that my election to reduce my compensation could affect my Social Security benefits and other wage-based social insurance programs. I further understand that the deduction elections indicated above will remain in effect for the entire Plan Year and cannot be changed or revoked unless I experience a qualified change in family status as defined by the law. I understand that my signature on this election form constitutes a formal salary reduction agreement between my Employer and me, and the election will be effective as provided by the Plan.

Date	Employee Signature

Employer Use Only: *Date of First Salary Reduction:* ______________ *# of Payrolls:* _______

© 2006 Vita Administration Company