Flexible Spending Accounts Enrollment Form

Effingham CUSD#40: Plan Year September 1, 2020 – August 31, 2021

EMPLOYEE INFORMATION

Full Name: _____ SS # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Date of Birth: _____

❑ **Please check box if you have had an address change since last plan year.**

ENROLLMENT TYPE

❑ Open Enrollment

❑ Qualifying Event/Status Change (please include a completed Status Change Form)

Complete only if eligibility is ***AFTER*** **Jan**1 Open Enrollment period:

❑ New Hire

Eligibility Date _____ First Payroll Date _____

PAYROLL FREQUENCY

❑ Weekly (52) ❑ Bi-Weekly (26, 24) ❑ Semi-Monthly (24) ❑ Monthly (12) ❑ Other

ELECTION AMOUNT

By my signature below, I authorize my Employer to make salary reduction contributions on my behalf to the following Flexible Spending Account(s) for the Plan year:

	Per Pay Period	*Annual Election*	
Dependent Care Account (DCA)	$_____	$_____	❑ Decline Coverage
$5,000 max per family or $2,500 per spouse when married and filing separate tax returns (per IRS)			
Health Flexible Spending (FSA)	$_____	$_____	❑ Decline Coverage
$2,750/yr maximum			

** Will you or your spouse have or open an HSA during the plan year?

_____ No, I do not have an HSA _____ Yes, I do have an HSA

TERMS AND CONDITIONS

PLEASE READ CAREFULLY*:* I understand that ***premiums for applicable group health, dental, vision, or group term life, etc. will automatically be deducted on a pre-tax basis unless I sign the attached separate waiver form. A separate enrollment form must be completed for each insurance benefit***.**

- I have received the Summary Plan Description (SPD). It is my responsibility to read and refer to the SPD for complete rules, regulations and restrictions and seek out my benefits administrator and/or BPC for questions or clarifications.
- I will not be permitted to change this election until the Annual Election Period except for the following changes in circumstances: marriage; divorce; death of spouse or child; increase or decrease in number of dependents; employment or termination of employment of spouse; change in employment status or location of employee; significant change in health insurance premium. I further understand that any change requested must be consistent with the change in circumstances that lead to such request.
- The Salary Reduction Contribution amounts elected above for any one Flexible Spending Account cannot be transferred to another Flexible Spending account and that any amounts remaining in my account(s) after the run-out period and any applicable roll-over or grace period, will be forfeited.
- If I should terminate employment I will be eligible to submit claims for health and child/dependent care reimbursement until the earlier of 1) the date the Flexible Spending Account balance is $0, or 2) the last day of the claim filing period. Health claims must be incurred prior to date of termination.
- I certify that all expenses for which I will request reimbursement for under these reimbursement accounts are valid expenses under the Plan and the Internal Revenue Code. I also certify that they are not reimbursable under another plan or source and may not be claimed on any federal income tax deduction or credit. If I have inadvertently received payment for an ineligible expense, I agree to provide repayment to the plan.
- I acknowledge that my participation in the Health Flexible Spending Account, except for certain limited-purpose Health FSA's, may disqualify myself and/or my spouse from opening or contributing to a Health Savings Account (HSA) for the duration of the FSA plan year.
- I understand that generally a Qualifying Individual for Dependent Care Expenses must be less than 13-years-old, or be incapable of self-care, and must share my same principal abode for more than half the year. Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent even when the noncustodial parent is entitled to claim the dependency exemption for the child.

_____ _____

Signature of Employee Date

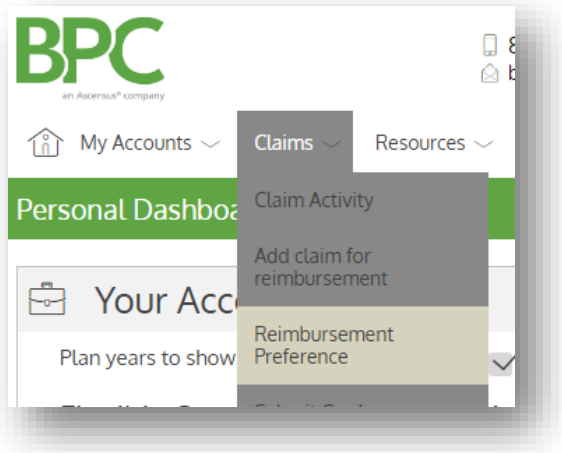
PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Save time and hassle by signing to have BPC-issued reimbursements deposited directly into the account of your choice. If you already have reimbursements issued this way, you do not need to sign up again. There are two ways to sign up:

1. **Online Authorization:** You may enter your banking information online by logging in to the BPC web portal (bpc.wealthcareportal.com), and clicking on Reimbursement Preference under the Claims drop-down menu. You may need to Register if you have not already done so. Online authorization will take **immediate** effect.

2. **Paper Authorization:** You may also sign up by completing the form below and submitting via mail to the address at the bottom of this page. Please **allow 3-5 business days** for processing of paper forms before new method or account will take effect.



I hereby authorize BPC, Inc. to initiate credit entries for my Flexible Spending Accounts, Health Reimbursement Arrangements and/or Transportation and Parking accounts to the bank account indicated below and the depository named below, hereinafter called DEPOSITORY. If any credit entries are made in error, this authorization shall allow BPC to initiate corrective debits against the depository account.

ACCOUNT INFORMATION:

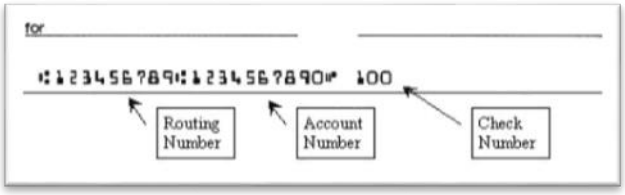
DEPOSITORY (BANK) NAME_____

CITY _____ STATE _____ ZIP _____

ROUTING NUMBER _____ ACCOUNT NUMBER _____

DEPOSITORY ACCOUNT TYPE:

❑ **CHECKING** ❑ **SAVINGS**



This authority is to remain in full force and effect until BPC has received written notification from me of its termination in such time and in such manner as to afford BPC and DEPOSITORY a reasonable opportunity to act on it.

COMPANY NAME: (please print) _____

EMPLOYEE NAME: (please print) _____

EMPLOYEE E-MAIL: _____ **PHONE:** _____

EFFECTIVE DATE: _____ **SSN: XXX-XX-**_____

SIGNATURE: _____ **DATE AUTHORIZED:** _____

BPC, Inc.
2110 Clearlake Blvd., Suite 200
Champaign, IL 61820

www.bpcinc.com

Health Care FSA Claim

part of FuturePlan by Ascensus®

MAIL:
PO BOX 7500
CHAMPAIGN, IL
61826-7500

FAX:
877-760-7076

PHONE:
877-272-8880

ONLINE:
www.mywealthcareonline.com/bpcinc

##11BPC001##################

Employer: _____

Participant Name (please print): _____ SSN: X X X – X X – ____

Day Time Phone Number: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ Email Address: _____

☐ I have **Changed** My Address _____
Street City State ZIP

NOTE: Please do not send original documentation to BPC. All items submitted (receipts and otherwise) will be considered property of BPC and will not be returned to you. **The IRS has determined that cancelled checks, check carbons, balance forward or previous balance statements, as well as charge card receipts or statements are NOT acceptable documentation of expenses.** Expenses **MUST** have been incurred during the coverage period. All submitted bills/receipts/statement/EOB **must be itemized** with the date of service, service provided/or item purchased, and the amount charged. **All supporting documentation MUST be included**

Expense Description	Dates of Service (From—To)	Provider	Claimant/ Patient	Amount of Purchase
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			AMOUNT REQUESTED:	$

FSA = Medical Flexible Spending Account (Flex)

I have included supporting documentation from an independent third party verifying that the eligible expense(s) has/have been incurred in the amount of the listed expense. By my signature below, I certify that all of the expenses listed on this form are valid and eligible and have been incurred by myself and/or my spouse and/or my eligible dependents. The expense(s) has/have not been discounted via coupon, rebate or other discount program, nor reimbursed in any way, and I will not seek reimbursement. I understand that the expense(s) for which I am reimbursed may not be used as deductions or credits on my, or my spouse's, income tax return. If I have inadvertently received payment for an ineligible expense or have been incorrectly reimbursed, I agree to provide repayment to the Plan.

A signature is required on each claim form that is submitted.

Participant Signature: _____ Date Submitted: _____

www.bpcinc.com/mobile-app

www.mywealthcareonline.com/bpcinc

www.bpcinc.com/fsa-extras

Dependent Care FSA Claim

part of FuturePlan by Ascensus®

MAIL:
PO BOX 7500
CHAMPAIGN, IL
61826-7500

PHONE:
877-272-8880

FAX:
877-760-7076

ONLINE:
www.mywealthcareonline.com/bpcinc

##11BPC001##################

Employer: _____

Participant Name (please print): _____ SSN: X X X – X X – _ _ _ _

Day Time Phone Number: (_ _ _) _ _ _ – _ _ _ _ Email Ad- _____

☐ I have **Changed** My Address _____
Street City State ZIP

NOTE: IRS regulations allow payment of services for dependents under age 13 and/or otherwise Qualifying Individuals as defined in the Plan document. The expenses must be incurred while you (and your spouse, if you are married) are at work . There is an exception if your spouse is not working or looking for work, then or she must be a full-time student

Dependent Name	Provider Name	Dates of Service (From—To)	Date of Birth	Age	Amount Requested
					$
					$
					$
					$
					$
					$
				Total Requested:	$

AFFIDAVIT: (Your care provider(s) only need to sign this if you do not have supporting documentation, such as an itemized receipt.)

I hereby certify that I provided adult or child daycare services to the above individuals in accordance with the amounts and dates that are requested.

Provider Signature: _____ Date Submitted: _____

Provider Signature: _____ Date Submitted: _____

PLEASE READ CAREFULLY: *By my signing below, I authorize the above expenses to be reimbursed from my DCAP Account. To the best of my knowledge, my statements in this form are true and complete. I certify all of the following: My family member has received the services described above on the dates indicated which is after the date I elected to receive DCAP Benefits and during the Plan Year to which the election applies. The expenses qualify as valid Dependent Care Expenses as defined in the Plan document. The expenses listed are for a Qualifying Individual as defined in the Plan. These expenses have not been previously reimbursed under the DCAP or any other plan, and I will not seek for them under insurance or any other Plan. I understand that the expenses reimbursed may not be used to claim an federal income tax deduction or credits (such as the Dependent Care Tax Credit). I agree to file IRS form 2441 with my tax return and provide any required provider information including taxpayer identification numbers. I can only be reimbursed for my Dependent Care expenses after the date of service has passed. If my DCAP balance is less than the amount requested, the difference will be held until the balance in my account is sufficient to pay the expenses.*

Participant Signature: _____ Date Submitted: _____

www.bpcinc.com/mobile-app

www.mywealthcareonline.com/bpcinc

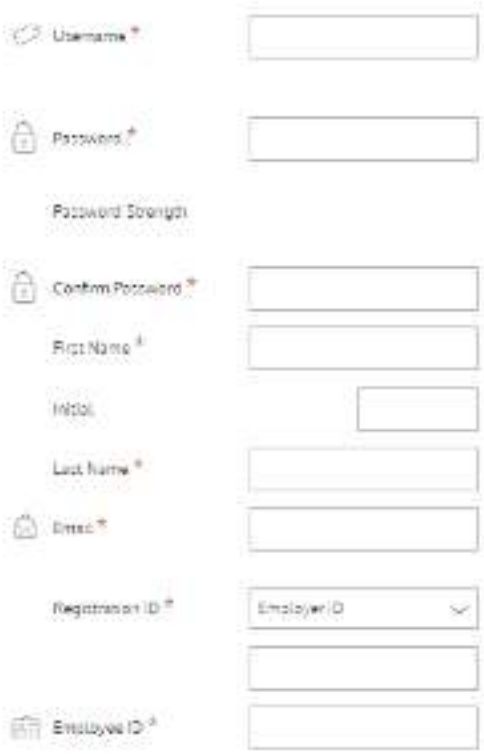
www.bpcinc.com/forms-participants

Web Portal/Mobile App Registration Instructions
For FSA/DCA Participants of Effingham CUSD #40

Use the BPC web portal or mobile app (search "BPC Benefits" in your app store) to manage every aspect of your account on the go!

Step 1: Go to https://bpc.wealthcareportal.com and click "Register". *If you are on a mobile device click on "Register" upon opening the app.*

Step 2: Enter your personal information in the fields provided.



Your **username** must be unique, and may be an email address

Your **password** must be at least 8 characters and include 3 of 4 character types.

1. Upper case letter
2. Lower case letter
3. Number
4. Special character (e.g. !, $, *)

Your **Registration ID/Employer ID** will be BPCEFFING

Your **Employee ID** will be your SSN (entered with no dashes)

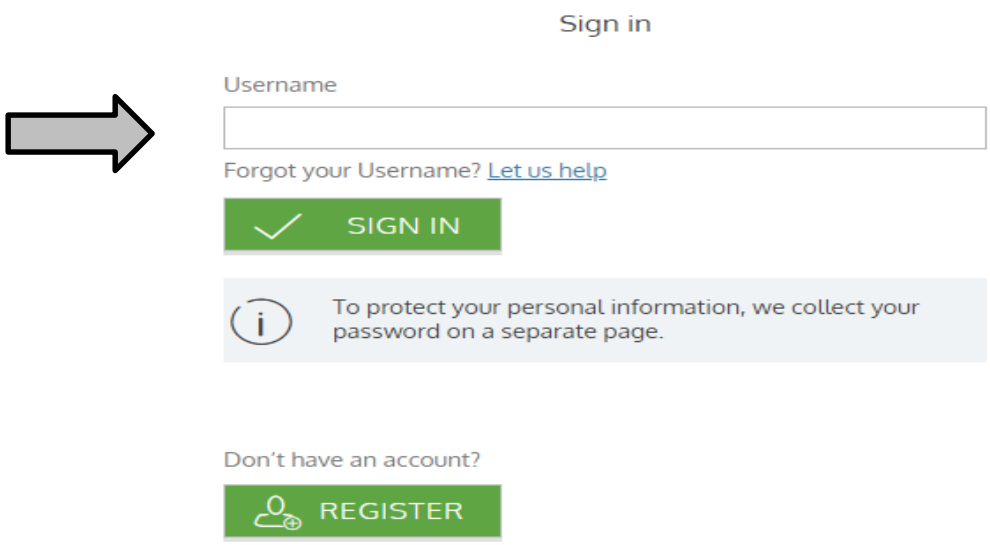
Step 3: Follow the additional steps to create a set of personal questions and answers, which can be used for password retrieval in the future.

Step 4: Verify all of your information, and submit!

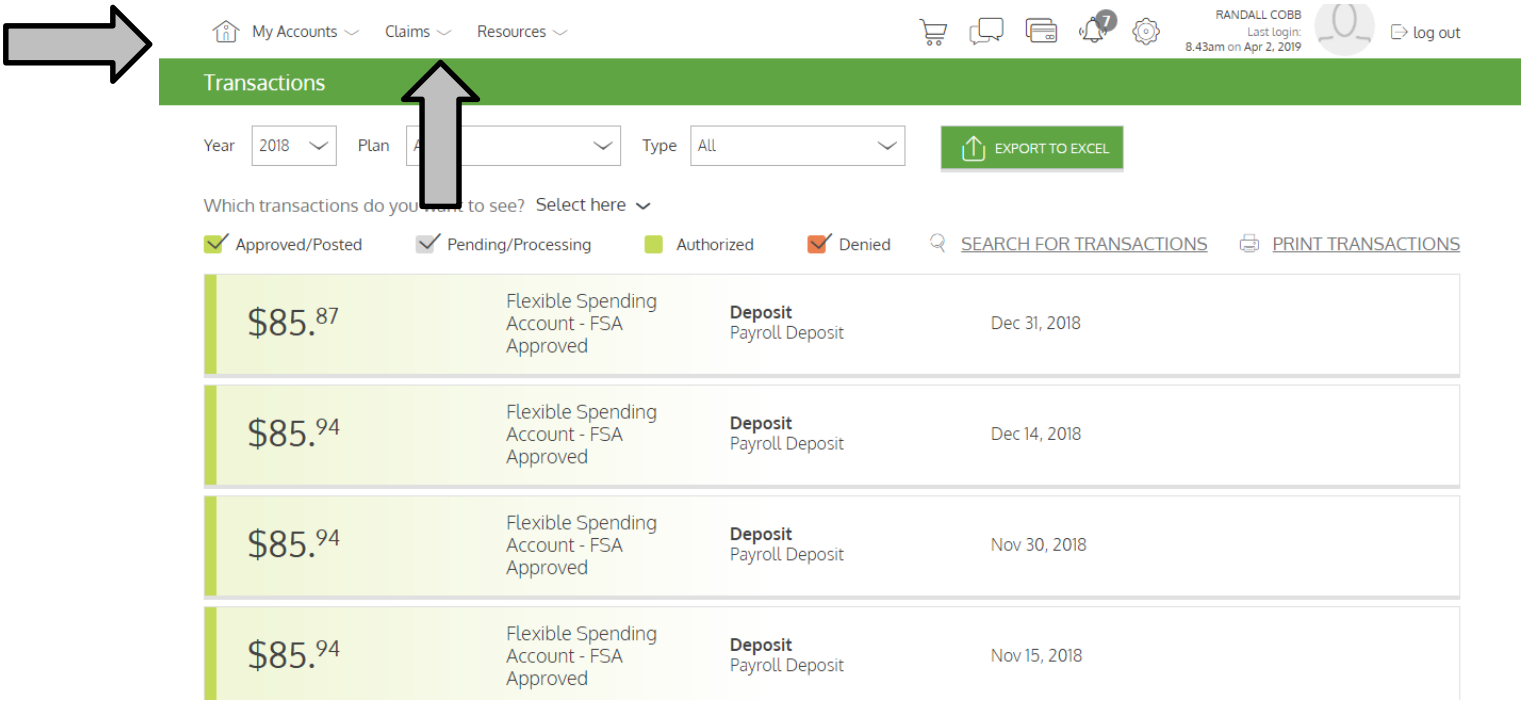
Forget something? – You can retrieve your username by clicking next to "Forgot Your Username" or your password by entering your username, hitting Continue, and then clicking "Forgot Your Password?"

Submitting a Claim – Online

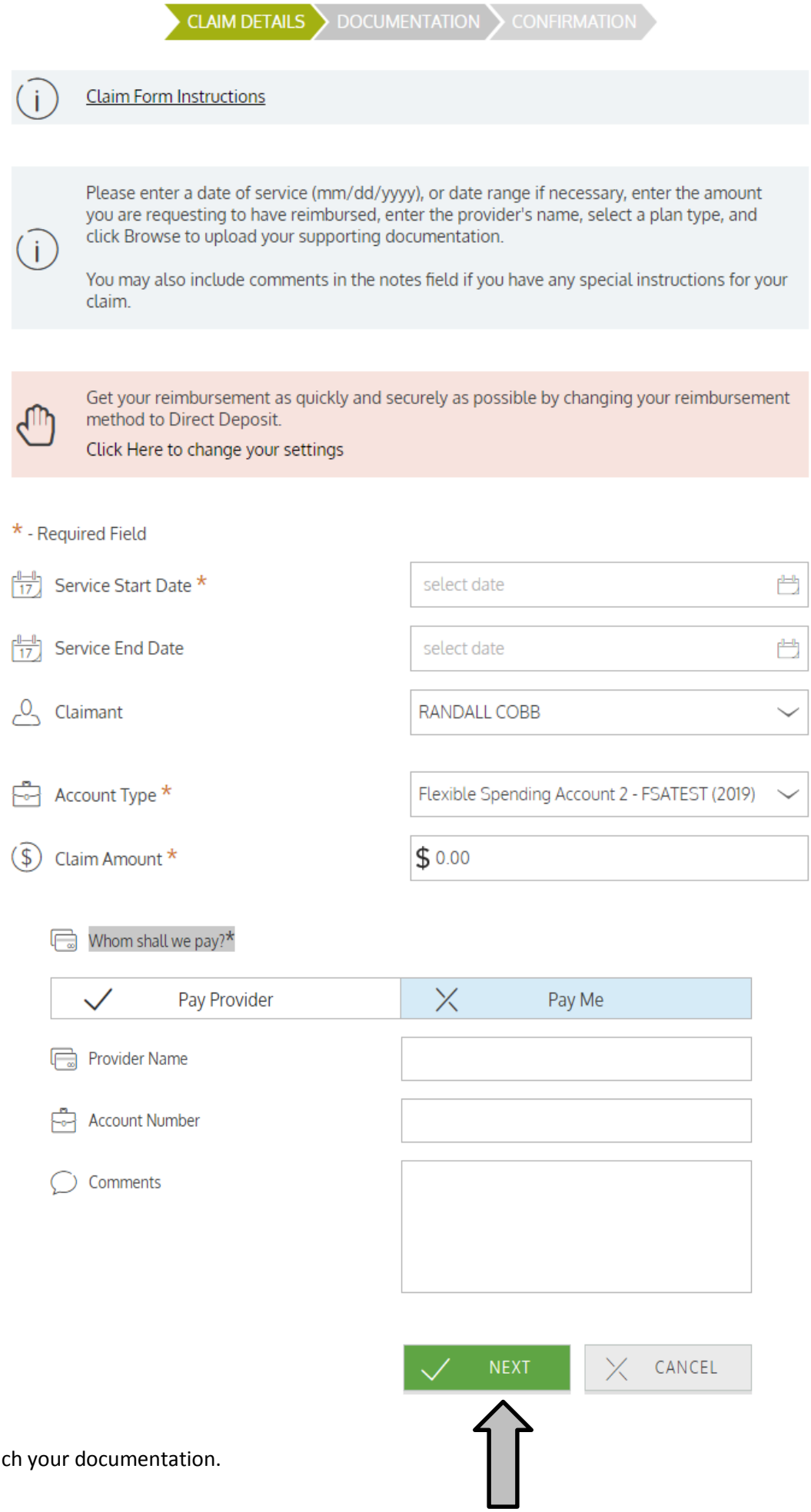
1. Got to https://www.mywealthcareonline.com/BPCinc/ and log in.



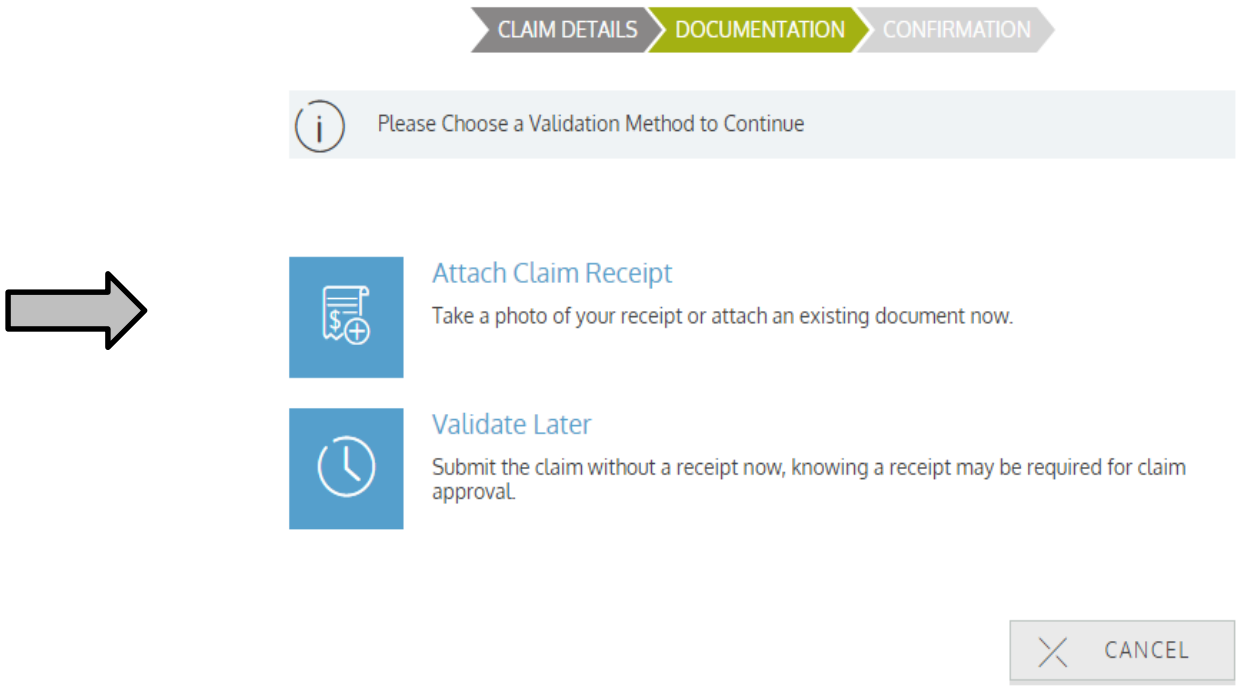
2. Once you have logged in, under the Claims arrow you will go to Add Claim for Reimbursement.



3. Fill out corresponding information, choose the correct claimant, you can add the name of the provider and comments if you like.



4. Click Next to attach your documentation.



5. Read the disclaimer, click on the box next to "I authorize these expenses to be reimbursed." Then Click Submit.