# Consumer-Driven Plans Election Form

Please confirm with your employer which of the benefits listed below are being offered.

Complete, sign and return this form to your employer before the end of the enrollment period.

*** = Required Fields** **Please print clearly.**


**Email:** benefits@workablesolutions.com

**Fax:** 1-866-234-3539 (toll-free)

**Mail:** Workable Solutions
Consumer-Driven Plans
7120 Lake Ellenor Drive
Orlando, FL 32809


## Step 1: Participant Information

**Check One:** ❒ **Open Enrollment** ❒ **New Hire** ***Desired Effective Date** (mm/dd/yyyy) ____________________

*Company Name ________________________________________ Division ____________________

*Your Name ________________________________ *Soc.Sec. # ☐☐☐-☐☐-☐☐☐☐

*Mailing Address ____________________ Employee ID #________________ Medicare ID #________________

*City ________________________________ *State ______ *Zip __________

*Payroll Frequency

❒ Weekly (52) ❒ Semi-Monthly (24)

❒ Bi-Weekly (26) ❒ Monthly (12)

Daytime Phone: (_______) __________ *Hire Date ____/____/______

Marital Status: ❒ Single ❒ Married *Date of Birth ____/____/______ Email Address ______________________________

(Used to communicate plan and claims information)

**Dependents:** (Attach separate sheet if needed.) All of the following information including SSN is **mandatory** for claims processing.

| | Name | Gender | Relationship | DOB | SSN | Medicare ID # |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |

## Step 2: Benefit Selection

### Pre-Tax Payment of Group Insurance Premiums

Employee contributions toward group benefits will automatically be deducted on a pre-tax basis. The pre-tax deduction may increase or decrease as your employer makes changes to employee contributions. If you do not want pay your portion of premiums pre-tax, contact your employer.

| | | MedFlex FSA<br>Up to max set by employer | | Limited MedFlex FSA<br>(If applicable) | CareFlex Dependent Care<br>Up to employer or IRS max | MedFund HRA<br>Employer Funded Account |
|---|---|---|---|---|---|---|
| **Annual Election** (Total Plan Year Contribution) | $ | | OR | | | |
| **Number of Pay Periods** (If mid-year enrollment, enter number of pay periods left in the plan year.) | ÷ | | | | | |
| **Per Pay Period Deduction** (To be deducted) | = | | | | | |
| **Date of First Payroll** (mm/dd/yyyy) | | | | | | |

**Commuter Assist Plans (if applicable)**

**Mass Transit/Van Pooling** **$**__________ **per month** (max $120/mo)

**Parking** **$**__________ **per month** (max $230/mo)

### By making contributions to these plans, I understand:

- I am authorizing my employer to reduce my gross earnings by the specified amounts in equal per pay-period installments during the Plan Year.
- I may use the funds for eligible out-of-pocket expenses incurred during the Plan Year, or by end of the Grace Period, if allowed by my employer. (The date of service, not the date of invoice, must fall within the Plan Year + Grace Period.)
- If I have not used all the funds within the Plan Year and Grace Period, the remaining funds will be lost.
- I cannot change my elections during the Plan Year unless there is a change in employment or family status which allows for a revocation or change.

## Step 3: Authorization or Waiver

**Participant Authorization**

❒ Please enrolll me in the plans checked above in the specified amounts indicated. I understand each plan has requirements, terms and restrictions which are contained in the Summary Plan Description. Any expenses reimbursed through the plan(s) cannot be claimed again as deductions or credits on my individual tax return. I authorize release of information needed to substantiate claims submiited for reimbursement.

**Participant Waiver**

❒ I do not want to participate. I understand that I wll not be able to enroll this plan year unless I have a qualifying event and elect coverage within the time frames estabished by my employer.

______________________________ ______________

Participant Signature Date