COVENTRY CONSUMER CHOICE℠

COVENTRY Health Care

HCFSA Enrollment/Change Form

Indicate type of Enrollment (check one):

☐ New Enrollment ☐ Re-enrollment (necessary each year if you wish to continue flexible benefits)
☐ Employee Termination ☐ Change in family status (as defined by your plan)

EMPLOYEE INFORMATION (Please Print)

☐ I have Coventry medical coverage ☐ I do not have Coventry medical coverage but wish to have a FSA *(only if offered by your employer)*

_____ _____ _____
Employer Name | Group Number | Employer Location Code (if applicable)

_____ _____-_____-_____ _____/_____/_____ _____
Employee Name (Last, First, MI) | Social Security Number | Date of Birth | Sex (M/F)

_____ _____ _____ _____ _(___)_____
Address | City | State | Zip Code | Daytime Phone Number

BENEFIT ELECTIONS

Your pay period frequency (check one):
☐ Weekly (52/year) ☐ Bi-weekly (26/year)
☐ Semi-monthly (24/year) ☐ Monthly (12/year)

Flex Effective Date: _____/_____/_____
Flex Term Date: _____/_____/_____
Flex Change Date: _____/_____/_____

Health Care Flexible Spending Account:
(Health Care FSA) Maximum annual election is $2,500 for plan years beginning on or after 2/1/2012

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Annual Contribution		**Number of Pay Periods Per Year**		**Contribution per Pay Period**

***Example**: You want an annual contribution of $1000 and you are paid semi-monthly.*

$1000	÷	**24**	=	**$41.67**
Annual Contribution		**Number of Pay Periods Per Year**		**Contribution per Pay Period**

Instructions:

1. All employees must complete the Employee Information Section.
2. If you want to participate in the plan, complete the following steps:
   - Check the box indicating your pay period frequency.
   - Enter your flex effective, term or change date.
   - Enter the annual contribution amount and the number of pay periods indicated in the boxes provided. Divide the annual contribution by the number of pay periods to determine the contribution per pay period.
   - Sign and date the form under Authorization for Coverage below, and submit to your employer.

REMEMBER, re-enrollment is necessary every year, even if you wish your contribution to remain the same.

NOTE: Some type of expenses (e.g. over the counter drugs) will still need to be submitted manually for reimbursement using the FSA claim form

EMPLOYEE AUTHORIZATION

This authorizes my insurance company, prepayment organization, employer, hospital, physician, or pharmacy (or any of their agents) to release or receive information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

Authorization: I hereby authorize pre-tax deductions from my salary in the amounts required for the election(s) indicated above. I have read the applicable plan document and understand the terms of participation and reimbursement of expenses. I understand that my election to participate is binding for the benefit year, revokes any previous election and the deduction(s), if any, will be in effect for the entire benefit year and cannot be changed except for family status changes as specified under the provisions and definitions of the plan. I also understand that the amounts in my spending account may be used only for allowable expenses incurred in the benefit year, and that any unused amount for the benefit year will be forfeited. I further understand that future Social Security benefits may be affected should I elect pre-tax salary deductions. I hereby certify the above information to be true and correct to the best of my knowledge.

X_____ _____/_____/_____
Employee Signature | Date