Insperity

# HEALTH CARE FSA PLAN ENROLLMENT/CHANGE REQUEST

UnitedHealthcare
A UnitedHealth Group Company

## Enrollment/Change Request for Calendar Year 2012

**INSTRUCTIONS:** To enroll in or request a change under the Insperity Health Care Flexible Spending Account Plan (Health Care FSA) — Insperity Group Account Number **701650** — complete all applicable parts of this form, read the terms and conditions, sign and date the form and timely return the completed original to your Insperity payroll specialist. The Health Care FSA may be used **only** to reimburse eligible health care expenses. Visit **myuhc.com** for more information on eligible health care expenses.

**There is no waiting period to satisfy before you may enroll in Insperity's Health Care FSA Plan.** To enroll, you must submit a completed and signed Health Care FSA Enrollment/Change Request (either online or via paper form) **within 30 days of becoming eligible** (i.e., your full-time hire date).

**If you fail to submit a completed form to Insperity within 30 days of becoming eligible, a mid-year election change event or a coverage reinstatement event, OR by the last day of the Health Care FSA's annual open enrollment period** (as applicable), **your election or change request will not become effective.**

### A. Employee Identification

(please print legibly)

**Please provide only ONE Employee Identification number below.** If at all possible, the preferred ID number is your Insperity Employee ID No. (the primary identifier required by Insperity's data system). If you have received an Insperity paycheck, your Insperity Employee ID number appears on your paystub. If you are a new employee and have not yet received your Insperity Employee ID number, please provide a full Social Security No. to facilitate accurate initial identification. Insperity stringently protects the privacy of all personal identification information.

| Employee Last Name | First Name | Middle Initial | Insperity Employee ID No. (if available) |
|---|---|---|---|
| | | | OR |
| Employee Daytime Area Code, Phone No. and Ext. ( ) | | | Last 4 Digits of Employee Social Security No. |
| | | | OR |
| Client Company Name | | Client Company No. | Employee Social Security No. ___ – ___ – ____ |

### B. Enrollment/Change Designation (Check an applicable event box within the appropriate category below and follow associated instructions.)

**ENROLLMENT**

- ❑ **New Enrollee** *(upon first becoming eligible during the calendar year)*
- ❑ **Annual Health Care FSA Open Enrollment**

► *Read Section D and Terms of Participation.*
► *Complete only Section C.*
► *Sign, date & return form to Insperity.*

**ELECTION CHANGE REQUEST**

- ❑ **Mid-Year Enrollment Due to Change in Status / Other Mid-Year Election Change Request**
- ❑ **Coverage Reinstatement Event** (Other than leave of absence that does not exceed 12 weeks). *To request coverage reinstatement following a leave of absence that does not exceed 12 weeks (or any such longer continuation period required by state or federal leave law that applies to your coverage), complete and return the Health Care FSA Leave of Absence Designation form (available online in the Employee Service Center at insperityservices.com).*
- ❑ **COBRA Event:** ❑ Divorce, effective on ____/____/_____
  ❑ Dependent child losing eligibility, effective on ____/____/_____

► *Read Section D and Terms of Participation.*
► *Complete Sections C or E (as applicable) & F.*
► *Sign, date & return form to Insperity.*

**Enrollment Deadlines | Coverage Effective Dates | First Per-Pay-Period Deduction Dates:**

| If your Health Care FSA enrollment election is made: | Then Insperity must receive your signed enrollment form: | Your Health Care FSA coverage will usually begin on: | And your corresponding per-pay-period deductions will begin on: |
|---|---|---|---|
| During **annual FSA Open Enrollment** | By the last day of the annual FSA Open Enrollment period | The first day of the next calendar year | The first pay date of the calendar year |
| As a **newly eligible employee** during the calendar year | Within **30 days** of your first becoming eligible to enroll in the Health Care FSA | The **first day** of first full pay period that occurs after enrollment request is processed by Plan Administrator | The **pay date** for first full pay period that occurs after enrollment request is processed by Plan Administrator |
| **As a mid-year Election Change Request** | Within **30 days** of the change-in-status event that qualifies you to change your election mid-year | The **first day** of first full pay period that occurs after change request is processed by Plan Administrator | The **pay date** for first full pay period that occurs after change request is processed by Plan Administrator |

### C. Elect Coverage — Designate a Monthly Contribution Amount

**You may elect a Health Care FSA monthly contribution amount ranging from $20 to $250 (in multiples of 10) to obtain an annual coverage level.**

If you enroll during the annual open enrollment period beginning Jan. 1, your coverage under the Health Care FSA for the calendar year will be equal to your monthly election multiplied by 12.

If you enroll mid-year, your coverage under the Health Care FSA for the remainder of the calendar year will be equal to your per-pay-period deduction amount multiplied by the remaining pay periods in the year.

**Check ONLY ONE box below to indicate a monthly contribution amount you elect to have deducted from your pay for Health Care FSA coverage:**

| | | | | | |
|---|---|---|---|---|---|
| ❑ $20 (minimum monthly contribution amount) | ❑ $30 | ❑ $80 | ❑ $130 | ❑ $180 | ❑ $230 |
| | ❑ $40 | ❑ $90 | ❑ $140 | ❑ $190 | ❑ $240 |
| | ❑ $50 | ❑ $100 | ❑ $150 | ❑ $200 | ❑ $250 (max. monthly contribution amount) |
| | ❑ $60 | ❑ $110 | ❑ $160 | ❑ $210 | |
| | ❑ $70 | ❑ $120 | ❑ $170 | ❑ $220 | |

### D. Example — Contribution Amount Calculation

Your Health Care FSA Plan contribution amount will begin as a per-pay-period deduction after your signed and completed Enrollment/Change Request form is processed by Insperity. To calculate your per-pay-period deduction amount, we annualize your monthly contribution election amount and divide by the total number of pay periods in the calendar year. The per-pay-period deduction amount may vary depending on any changes in pay frequency, available compensation, leave of absence or termination.

| Monthly Election Amt. | | 12 Months | | Pay Frequency | | Per-Pay-Period Deduction Amt. |
|---|---|---|---|---|---|---|
| $100 | x | 12 | ÷ | 26 | = | $46.15 |
| $200 | x | 12 | ÷ | 26 | = | $92.31 |
| $20 | x | 12 | ÷ | 26 | = | $ 9.23 |

*(Examples above assume bi-weekly pay periods.)*

### E. Terminate Health Care FSA Participation

❑ I elect to terminate my participation in the Health Care FSA for the remainder of the calendar year. I understand that my participation will cease and any health care expenses incurred after my participation ends will not be eligible for reimbursement under the Health Care FSA.

► *Read Terms of Participation.*
► *Skip Sections C & D and complete Section F.*
► *Sign, date & return form to Insperity.*

## F. Mid-Year Election Change Request or Coverage Reinstatement Event

Complete this section if you are enrolling mid-year due to change in status, making another mid-year election change request, or requesting coverage reinstatement (other than a leave of absence that does not exceed 12 weeks, or any such longer continuation period required by state or federal leave law that applies to your coverage). To request coverage reinstatement following a leave of absence that does not exceed 12 weeks, please complete and return to Insperity the Health Care FSA Leave of Absence Designation form (available online in the Employee Service Center℠ at insperityservices.com).

**Any election change must be on account of and consistent with the election change event described below. Requests for election changes or coverage reinstatement must be made within 30 days of the election change or reinstatement event.**

**Check the event that applies to your Change Request:**

- ❑ **Change in Marital Status:**
  - ○ Marriage ○ Divorce or annulment
  - ○ Legal separation ○ Death of spouse
- ❑ **Change in Number of Dependents:**
  - ○ Birth ○ Death of dependent
  - ○ Adoption/placement for adoption
- ❑ **Judgment, Decree or Order (QMCSO) Requiring Coverage Under:**
  - ○ This Plan ○ Another employer's Plan
- ❑ **Entitlement to Medicare or Medicaid**
- ❑ **Dependent Gains or Loses Status as an IRC §152 Dependent**
- ❑ **Employment Status Change**
- ❑ **Coverage Reinstatement Event**
  (Examples: a mid-year termination and rehire; a change in employment status from full-time to part-time and back to full-time; or a return from a leave of absence that exceeds 12 weeks.)

**Provide a description below of the mid-year election change request or coverage reinstatement event you have indicated at left. Include names of any affected family members and date of the event:**

_____

_____

_____

_____

If you are currently participating in the Health Care FSA or are reinstating participation during the same calendar year in which you previously participated, your new annual coverage level for the remainder of the calendar year will be equal to your new per-pay-period deduction amount multiplied by the remaining pay periods in the calendar year, plus any contributions you have already made during the current calendar year.

Any amounts you have received in Health Care FSA reimbursements during the calendar year prior to your election change or coverage reinstatement will also be carried forward for the remainder of the calendar year. If you are first electing to participate in the Health Care FSA mid-year (on account of your marriage or the birth or adoption of your child, for example), your annual coverage level for the remainder of the calendar year will be equal to your per-pay-period deduction amount multiplied by the remaining pay periods in the calendar year.

### IMPORTANT

- **Under applicable IRS guidelines, individuals treated as self-employed for federal tax purposes are not eligible to participate in the Health Care FSA Plan**. Generally, the following individuals are considered self-employed for purposes of eligibility to participate in the Insperity Cafeteria Plan: (1) sole proprietors (and their spouses, if also employees); (2) partners; and (3) S corporation owners with greater than two percent ownership (and their spouses and/or lineal relatives, if also employees).
- **Your participation could affect cafeteria plan nondiscrimination testing.** As a general rule, the Health Care FSA contributions of company owners and officers cannot exceed 25 percent of total employee contributions for a given plan year. Simply stated, for every dollar contributed by an owner or officer, three dollars must be contributed by other employees in order to satisfy mandated annual nondiscrimination testing. If the 25% threshold is exceeded, there is a high likelihood that this FSA nondiscrimination test will not be satisfied, resulting in taxable income for owners and officers. Therefore, if you are a company owner or officer, you should consider not enrolling in the Health Care FSA. **Some additional exceptions and limitations may apply.** Please contact Insperity at 866-715-3552 for detailed information.

## Terms of Participation

*Read carefully these **Terms of Participation** before you make your election or election change. Your signature on this Enrollment/Change Request form will acknowledge that you have read and agree to these terms.*

**IMPORTANT:**
**Your Health Care FSA election does NOT automatically carry over from one year to the next.**

To continue participating in the Health Care FSA, you must enroll **each year** during the program's annual open enrollment, **generally held in late fall.**

- I agree that my compensation will be reduced each pay period by the per-pay-period deduction amount corresponding to the monthly contribution amount elected on this form for the calendar year to which my election applies.
- I understand that my election is void and I will not be a participant in the Health Care FSA if the Plan Administrator determines that I do not satisfy the eligibility rules of the Health Care FSA as of the date my election would have been effective, and Insperity may withhold from my compensation any tax amounts owed for contributions made while ineligible.
- **IMPORTANT:** I understand that IRS rules do not permit me to change or revoke my election during the calendar year unless a change in status event described in the Health Care FSA Summary Plan Description (SPD) occurs that lets me cancel or change my contribution election mid-year (e.g., marriage, divorce, birth or adoption of a child, death of a spouse or child). However, the Plan Administrator (in its discretion and with or without my consent) may reduce, stop and/or deem taxable my contributions at any time to the extent it deems appropriate for compliance with applicable law or the terms of the Health Care FSA.
- I understand that the Plan Administrator determines in its sole discretion whether any request for an election change or coverage reinstatement is permitted. I also understand the Plan Administrator may require documentation that an election change event has occurred.
- **I understand that my election is effective only for the calendar year to which it applies.** I will be offered an opportunity to make a new election each calendar year I am eligible to participate in the Health Care FSA during the open enrollment period that generally occurs in late fall, prior to such calendar year.
- I understand that any contributions I make will reduce my compensation for Social Security tax purposes, meaning that my Social Security benefits could be slightly decreased. I further understand that my participation in the Health Care FSA may have additional tax and financial consequences and that I should consult with my tax or legal advisor for more information.
- **I understand that IRS rules generally prohibit individuals with general purpose health care FSA coverage (including an eligible spouse and dependents) from contributing to a health savings account (HSA). I further understand that my participation in the Health Care FSA will make me ineligible to contribute to an HSA in the same calendar year.**
- I understand that only those eligible health care expenses incurred while I am a participant in the Health Care FSA may be submitted for reimbursement and that all claims for reimbursement must be filed by the March 31 immediately following the calendar year in which the expense was incurred. I further understand that any amounts remaining in my Health Care FSA for the calendar year and for which a valid claim has not been filed in a timely manner will be forfeited. This means that any unused Health Care FSA amounts will not be returned to me or carried over for use in a subsequent calendar year (the "use-it-or-lose-it" rule).
- I understand and agree that I must promptly repay any ineligible expenses paid to me through the Health Care FSA (as determined in the sole discretion of the Plan Administrator) and that Insperity may withhold from my compensation any such amounts in satisfaction of my repayment obligation.

| **I have read and agree to the Terms of Participation set forth on this form.** | Employee Signature | Date |
|---|---|---|

**Questions?** Contact Insperity toll-free at 866-715-3552 weekdays between 7 a.m. and 7 p.m. CT.
**PLEASE RETURN YOUR COMPLETED FORM TO YOUR INSPERITY PAYROLL SPECIALIST.**