



proven benefit solutions  
P.O. Box 1878, Tallahassee, FL 32302-1878

# State of Ohio

## FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Health Care Expense and/or Dependent Care Flexible Spending Account. For Open Enrollment Only: You may enroll online at [www.myFBMC.com](http://www.myFBMC.com)

Name (Please Print) Last		First		MI	Social Security #			
Home Address Street		City		State		ZIP		
Daytime Phone ( ) ( )		Home Phone ( ) ( )		Date of Hire	Date of Birth		Annual Salary	
E-mail Address								
ENROLLMENT STATUS: <input type="radio"/> OPEN ENROLLMENT <input type="radio"/> RE-ENROLLMENT <input type="radio"/> CHANGE IN STATUS <input type="radio"/> NEW HIRE								
CHANGE TYPE: _____ DATE: ____ / ____ / ____								

- Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
- Health care spending account and dependent care spending account worksheets are available at [www.myfbmc.com](http://www.myfbmc.com) as well as the following DAS webpage [das.ohio.gov/FlexibleSpendingAccount](http://das.ohio.gov/FlexibleSpendingAccount)
- If you have questions, consult your 2010 Flexible Benefits Plan Open Enrollment Brochure, or call FBMC Customer Service at 1-800-342-8017.
- Be sure to submit your enrollment form by October 30, 2009.
- Your effective date of participation will be January 1, 2010.

In Box #1, indicate the dollar amount you will contribute for the 2010 plan year.  
 In Box #2, indicate the number of regular payroll checks you expect to receive during the 2010 plan year.  
 In Box #3, indicate the deduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.)

By signing this form you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement or any other anticipated unpaid leave.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	
Use your Health Care FSA for eligible uninsured, out-of-pocket medical expenses incurred by you, your family members or both. (Annual allowable maximum contribution per participant is \$3,000)	
Box #1	Total plan year dollar amount from your worksheet _____
Box #2	24 for employees paid bi-weekly 12 for employees paid monthly     ÷     _____
Box #3	Reduction per regular paycheck     =     _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)		
TAX FILING STATUS – PLEASE CHECK ONE:		
<input type="radio"/> Married, filing separately [\$2,500 maximum]	<input type="radio"/> Married, filing jointly [maximum - \$5,000]	<input type="radio"/> Single, head of household [maximum - \$5,000]
Box #1	Total plan year dollar amount from your worksheet _____	
Box #2	How many consecutive pay periods for payroll deduction? _____	
	Employees paid bi-weekly (max of 24) _____	
	Employees paid monthly (max of 11) ÷ _____	
Box #3	Reduction per regular paycheck     =     _____	

All health care spending account participants will receive a myFBMC Card to facilitate accessing their accounts. This health care spending account debit card does not have a fee.

### IMPORTANT

- I hereby authorize my employer to reduce my gross salary before Medicare, local, state and federal income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with the contract administrator within 30 days of the event.
- I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from and I specifically release them from my participation in any FSA or my failure to sign or accurately complete this Enrollment Form.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE SIGNED
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SUBMIT YOUR COMPLETED FORM TO FBMC AT P.O. BOX 1878, TALLAHASSEE, FL 32303.

### FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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