ROCKY MOUNTAIN reserve

www.RockyMountainReserve.com

Flexible Spending Account Enrollment Form

Employer: _____

Plan Year: 20 _ _ **or** ___/___/___ **to** ___/___/___

This Enrollment Form is being used to: ***(Check one)***

- ☐ Initially enroll or annually re-enroll in the Cafeteria Plan
- ☐ Waive participation in the Cafeteria Plan

Participant Information

*Required fields

Employee Name* _____ **SSN*** _____

Last *First* *M.I.*

Address* _____

Street *City* *State* *Zip*

E-mail Address* _____ **DOB*** _____

mm/dd/yyyy

Enrollment Information

I elect to reduce my compensation for each pay period during the plan year and redirect such dollars into the Cafeteria Plan as set forth below.

☐ **Insurance Premiums:** **All eligible premiums will be automatically deducted Pre-Tax on my behalf UNLESS I check this box indicating that I wish to have these premiums deducted Post-Tax.**

	Contributions Per Pay Period	Number of Pay Periods	Annual Election
☐ **Health Care FSA**			
☐ **Dependent Care FSA**			
☐ **Limited Purpose FSA (Dental & Vision)**			

☐ **Debit Card**

I understand that I will automatically receive a debit card with my enrollment in the FSA plan and I would like to order a card for my spouse or dependent.

_____

Spouse or Dependent Name SSN Birth Date

Signature and Authorization

I understand that an election is made before a year begins and cannot be changed until the next year. No changes are allowed during the year unless there is a change of status. I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand, for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax on any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I agree to follow the terms and conditions set forth in the Summary Plan Description. The Plan Administrator may reduce my compensation reduction or otherwise modify this agreement in the event it is believed to be advisable in order to satisfy provisions of the Internal Revenue Code. My Social Security benefits may be slightly reduced as a result of my election. This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Company. If my employment is terminated I agree to contact Rocky Mountain Reserve regarding my account.

_____ _____

Employee Signature **Date**

Health Care Expense Planning Worksheet

*Not required, for employee use in estimating expenses

Common Medical Expenses	**Estimated Plan Year Total**
Medical Expenses:	
Co pays	_____
Deductible	_____
Chiropractor	_____
Prescriptions	_____
Other_____	_____
Dental Expenses	
Cleanings	_____
Fillings	_____
Crowns	_____
Other_____	_____
Vision Expenses	
Glasses	_____
Contacts	_____
Exams	_____
Lasik	_____
Other_____	_____
Over-The-Counter Expenses	
Band Aids	_____
Contact lens solution	_____
Pain Reliever (only with Rx)	_____
Other_____	_____
(Medicines, Vitamins and Supplements only with Rx)	
TOTAL:	_____

*All eligible out-of-pocket medical expenses for you, your spouse and your dependents can be reimbursed regardless of insurance coverage. A listing of eligible expenses can be found in the accompanying enrollment guide or http://rockymountainreserve.com/health-care-expenses-table.

Dependent Care Account

*A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you.

*The care must be necessary for you or your spouse to be gainfully employed or to go to school.

*Care may be provided by anyone other than your spouse or your children under the age of 19.

*Expenses for schooling, kindergarten and above, overnight camp and nursing homes are not reimbursable.

*The maximum you can elect, in a calendar year, is equal to the smallest of the following:
- -$5,000 – Married and filing federal taxes jointly or a single parent
- -$2,500 – Married and filing separate federal tax return

*The amount contributed year-to-date, is available for reimbursement.

All elected “Pre-Tax” amounts are exempt from Federal, State, FICA, and Medicare taxes.

Services must be incurred within the plan year in order to be eligible for reimbursement.

Be conservative in your election! Any amount that is not used during the plan year and/or applicable grace period will revert back to your employer.