LOOMIS
THE LOOMIS COMPANY

EMPLOYER SECTION
Group No: 305 **Effective Date:** _____
Location:_____ **Date of Hire:** _____
HR Rep./Date: _____

Reading School District FSA / DCA Benefits Enrollment Form

This enrollment form should be used to indicate your benefit elections . Please print and mark all selection boxes clearly.

Section 1: Employee Information

Full Name (First MI Last): _____ Sex: ☐ M ☐ F

Address: _____ Social Security No.: _____-_____-_____

_____ Date of Birth: _____/_____/_____

City: _____ Zip: _____ Home Phone: (_____) _____

Marital Status: ☐ Single ☐ Married _____/_____/_____ ☐ Legally Separated ☐ Divorced

E-Mail Address:_____

Section 2: Enrollment Option

FSA Election	
☐ **Employee**	☐ **2017 FSA Amount Elected $**_____
☐ **Waive Coverage**	☐ **2017 DCA Amount Elected $**_____

Section 3: Dependent Information

	Full Name (First MI Last)	Sex	DOB	Social Security No.	Eligible Dependent		Permanently Disabled Child?	
Spouse ☐ Add ☐ Drop		M F	/ /	- -				
Child ☐ Add ☐ Drop		M F	/ /	- -	☐ Y	☐ N	☐ Y	☐ N
Child ☐ Add ☐ Drop		M F	/ /	- -	☐ Y	☐ N	☐ Y	☐ N
Child ☐ Add ☐ Drop		M F	/ /	- -	☐ Y	☐ N	☐ Y	☐ N

Section 4: Other Insurance Information (Optional)

Do you or any dependents listed have coverage under another benefit plan? ☐ No ☐ Yes. Complete the following:

Name of Policyholder: _____ Name of Sponsoring Employer: _____

Name of Insurance Plan: _____ Type of Plan: ☐ Group ☐ Individual

Type of Coverage: ☐ Medical ☐ Vision ☐ Dental ☐ Medicare ☐ Champus

List covered Dependents from Section 5 above: _____

Section 5: Employee Authorization and Acceptance

I hereby certifiy that I have read the front side and reverse side of this enrollment form and agree to the terms of each Benefits Program that I am offered. *

Print Name: _____

Employee Signature: _____ **Date:** _____

*** I hereby certify that all information furnished is true to the best of my knowledge.**
*** I am required to contribute to the elected amount indicated on this form; I hereby authorize my employer to deduct such contributions from wages due to me.**
*** I have carefully read this application and agree to it's terms.**

I understand:
*** I or an eligible dependent has had a qualifying change in status, as defined by the Internal Revenue Service, which allows me to change my previous Healthcare Spending Account election**
*** If I cancel my Account contributions, I cannot claim reimbursement for expenses incurred for the remainder of the Calendar year unless I have another qualifying event and submit another change form to my employer.**
*** The FSA/DCA benefits, and my rights and obligations under this plan, as specified in my Summary Plan Description.**
*** This form cancels any prior elections I have made under this plan, and cannot be changed except as stated in my Summary Plan Description.**

Benefits Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance, reinsurance company, employer or third-party administrator having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the group policy holder, the plan sponsor, The Loomis Company - Benefits Division, or its legal representative any and all such information. Any medical information obtained will not be released to any person or organization except for those associated with our benefits programs, unless lawfully required to receive it.

I acknowledge that I may request a copy of this Authorization. I furthermore acknowledge that a photographic copy of this authorization shall be as valid as the original.

In the event I elected to waive/cancel my enrollment at this time in one of the Benefit Plan options, I understand I cannot enroll at a later date unless I meet one of the following provisions: 1) meet the Special Enrollment Requirements under HIPAA; 2) experience a Qualified Change in Family Status; 3) enroll during the Annual Open Enrollment Period. I understand my employer has HIPAA Privacy Information available should I need further information about the law and how it affects me and my family.

Debit Card Authorization

I have read and understand the rules regarding the use of my debit card for eligible Health Care expenses. I certify that the card will only be used for eligible expenses at eligible providers. I further certify that the amount of eligible expenses is not reimbursable from any other source, nor will I attempt to be reimbursed from any other source. I will maintain substantiation for all expenses and where required, provide applicable substantiation upon request. Failure to provide such documentation can result in my debt card being turned off, and I will be required to repay the plan for the expenses in question. Repayment can be made via personal check or money order. If payment is not received within 45 days these moneys will be deducted from my paycheck or collected via other acceptable methods as dictated by the Internal Revenue Ruling. If I terminate employment or participation in the plan, I will return the debit card to my employer.

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person filing an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is committing a fraudulent act which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT - PLEASE SIGN THE FRONT SIDE OF THIS ENROLLMENT FORM AS YOUR ACKNOWLEDGEMENT AND ACCEPTANCE OF THE ABOVE INFORMATION.

FOR USE BY THE LOOMIS COMPANY	
Account:	
Location:	
Eff Date Employee: _____	**Processed Date:** _____
Eff Date Dependent: _____	**User ID:** _____
Remarks:	