LOOMIS
THE LOOMIS COMPANY

EMPLOYER SECTION

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

Reading School District
2018 FSA & DCA
Benefits Enrollment/Change Form

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

MUST Select One:	☐ New Enrollment ☐ Open Enrollment ☐ Name Change ☐ Address Change	Date Of Occurence Add Dependent(s): ☐ Marriage: _____ ☐ Newborn: _____ ☐ Adoption: _____ ☐ Other: _____	Date Of Occurence Drop Dependent(s): ☐ Marriage: _____ ☐ Divorce: _____ ☐ Other: _____ ☐ Death: _____ ☐ Age Limit: _____	☐ COBRA Event Date of Occurence ☐ Termination of Employment: _____ ☐ Reduction of Hours: _____ ☐ Divorce: _____ ☐ Dependent Not Eligble: _____ ☐ Age Limit: _____ ☐ Death: _____ ☐ Waiver: _____

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: Medical Flex Spending Account (FSA)

FSA Election	DATE OF FIRST PAYROLL DEDUCTION: ___/___/___
☐ Employee ☐ Waive Coverage	☐ 2018 Annual Amount Elected $_____ Maximum Allowed: 2018: Election $2650.00

Section 3: Dependent Care Spending Account (DCA)

DCA Election	DATE OF FIRST PAYROLL DEDUCTION: ___/___/___
☐ Employee ☐ Waive Coverage	☐ 2018 Annual Amount Elected $_____ Maximum Allowed: 2018: Election $5000.00

Benefits Authorization

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 Flexible Spending Account and/or Dependent Care Assistance Program election
* If I cancel my Flexible Spending Account contributions, I cannot claim reimbursement for expenses incurred for the remainder of the 2016 unless I have another qualifying event and submit another change form to my employer (this does not apply to DCA participants).
* The FSA and 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.

Section 6: 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:** _____

Benefits Authorization

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.

I hereby apply for the coverages for which I am entitled under the terms of the employer's Benefits Programs and I agree to pay any required costs. I understand my employee contributions for the Benefit Plans will automatically be deducted from my paycheck on a before-tax basis from year to year, unless I notify the HR Department in writing otherwise and that, if offered, Flex Spending requires a new election each year. I also understand I cannot change my elections during the year unless I have a Qualified Change in Family Status or I meet the plans Special Enrollment requirements.

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 and or Dependent care FSA 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:	