RESET

Horizon Blue Cross Blue Shield of New Jersey

Unreimbursed Medical/Dependent Care Flexible Spending Account (FSA) Election Form

(Utilize the worksheet to help you determine your election for next year.)

Please return this form to your employer.

Employer Name: _____

Employee Name *(please print)*: _____

Social Security #: _____ Date of Birth:_____

Home Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Home Phone #: _____ Work Phone #: _____

Date of Hire: _____ Effective date: _____

First Payroll Date: _____ Payroll Frequency: _____

Unreimbursed Medical

☐ I elect to participate in the Unreimbursed Medical Flexible Spending Account. I direct and authorize my employer to reduce my annual salary for the plan year _____ by $ _____. I understand that my salary will be reduced in **equal amounts** from my regular paycheck.

☐ I elect **not** to participate at this time.

Dependent Care

The total amount I can deposit into my Dependent Care Flexible Spending Account cannot exceed the lesser of $5,000 ($2,500 for a married person filing separately) or my spouse's earned income. **If my spouse does not work and is not disabled or a full-time student, I cannot participate in the Dependent Care Spending Account.**

☐ I elect to participate in the Dependent Care Flexible Spending Account. I direct and authorize my employer to reduce my annual salary for the plan year _____ by $ _____ (maximum $5,000 – see above). I understand that my salary will be reduced in equal amounts from my regular paycheck.

☐ I elect **not** to participate at this time.

I understand the following: This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of, and consistent with, a change in family status (legal separation, divorce or marriage; birth or legal adoption of a child; death of a dependent; change in work status for you or your spouse; or change in cost or coverage for dependent care).

I can continue to file claims for expenses incurred during the plan year until three months following the end of the plan year. Funds not used during the plan year are forfeited*. In effect, I must use-it or lose-it.

* Unless your employer has adopted the rollover option.

Your Signature _____ Date _____

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Plan Enhancements

Interactive Website

Visit HorizonBlue.com/fsa.

- **Online Worksheets**
  - Dependent Care vs. Federal Tax Credit.
  - Unreimbursed Medical Worksheet.
- **Online Claim Entry Module**
  - Submit your Unreimbursed Medical and Dependent Care claims online. Receipts must be uploaded immediately to receive reimbursement.
- **Downloadable Forms**
  - Download and print Flexible Spending Account forms: FSA Election Form, Direct Deposit Enrollment, Change in Status and more.
- **Online Account Balance Inquiry**
  - Receive up-to-date account balance information.
- **Online Claim List**
  - Provides information on the most recent claims submitted.
- **Online Payment List**
  - Details the most recent FSA payments issued from your account(s).
- **Direct Deposit**
  - Participants will be able to elect direct deposit of FSA reimbursements into a checking or savings account.
- **Over-the-counter drugs**
  - Most eligible over-the-counter drugs will require a physician's prescription to be reimbursed under the FSA.

Worksheet

Unreimbursed Medical FSA		
List the amount you spent for:	Prior Year Actual Expenses	Projected Expenses
Deductibles/coinsurance/copayments	$	$
Eligible over-the-counter drugs with a prescription[1]	$	$
Vision care/LASIK eye surgery (eye exams, contact lenses and solutions and eyeglasses)	$	$
Routine exams if not covered by insurance (Ob/Gyn, well visits, etc.)	$	$
Prescription drugs (Does not include cosmetic prescriptions)	$	$
Chiropractor/acupuncturist/mental health visits	$	$
Travel costs related to medical care	$	$
List the amount you spent for out-of-pocket dental expenses:		
Examinations, cleanings and X-rays	$	$
Fillings, crowns and bridges	$	$
Orthodontics	$	$
Dentures, implants, periodontics	$	$
Total	$	Total $
Projected Unreimbursed Medical FSA deposit	$	$

Dependent Care FSA		
	Prior Year Actual Expenses	Projected Expenses
Dependent care services provided in your home[2]	$	$
Day care center	$	$
Preschool/Nursery school	$	$
Before- and/or after-school care	$	$
Summer day camp facility	$	$
Total	$	Total $
Projected Dependent Care FSA deposit	$	$

[1] Most of these eligible drugs will require a prescription to be reimbursable.

[2] Must provide taxpayer ID.

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