Health Care Flexible Spending Account Enrollment/Change Form

CIGNA

☐ **INITIAL ELECTION** ☐ **CHANGE** ☐ **TERMINATION**

EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NO. *(Required)*	EMPLOYER NAME *(Required)*		
EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	M.I.	DATE OF BIRTH
EMPLOYEE ADDRESS			
CITY		STATE	ZIP/POSTAL CODE

PRE-TAX FLEXIBLE SPENDING ACCOUNT

Choose the annual amount you would like to have withheld from your salary and placed into a Health Care Flexible Spending Account for reimbursement of eligible health care expenses.

Annual Amount Elected: $_____
(not a per pay period amount)

Annual amount elected will be divided by the number of pay periods in the Plan Year.

AUTHORIZATION

I hereby authorize my employer to reduce my earnings by the amount stated above for deposit into my Health Care Flexible Spending Account and to make this money available to me for the reimbursement of health care out-of-pocket expenses as appropriate. I understand that I will forfeit any unused balance in my account at the end of the Plan Year. I also understand that I cannot change my plan participation during the Plan Year unless I have a change in family status, as defined in the Regulations under Internal Revenue Code Section 125.

SIGNATURE	DATE

DEBIT CARD

If you elect a Health Care Flexible Spending Account (FSA), you may be eligible to receive an FSA debit card to access your health care FSA funds and pay for qualified health care expenses. Please check with your employer to verify if this is a benefit feature available to you.

You can use the debit card at the time of service at any pharmacy, doctor's office or other vendor for qualified health care goods and services up to your available balance. You may also submit the debit card number to providers to pay for qualified charges.

The card may be used for qualified expenses only. Please keep all itemized receipts and statements. You will be required to submit receipts to CIGNA HealthCare to document your debit card expenditures.

By enrolling in the Health Care FSA and receiving a debit card, you agree to read and adhere to the provisions in the cardholder statement you receive with the card and understand the card may be deactivated if you do not comply with those provisions. Your card also will be deactivated if you end your employment or are no longer enrolled in the Health Care FSA.

If you are enrolled in the Choice Fund Health Savings Account (HSA) or a medical plan that qualifies you to contribute to an HSA, the HealthCare FSA funding of medical or pharmacy expenses is limited.

Please sign and date this section of the form, to indicate your election:

I certify that any expenses submitted to the Flexible Spending Account or paid for with the FSA Debit Card on my behalf have been incurred by me or my eligible dependents and have not been reimbursed by any other source, nor do I expect them to be. I agree to notify the CIGNA HealthCare Reimbursement Account Unit immediately if any of these expenses are reimbursed from any other source.

SIGNATURE	DATE

FOR EMPLOYER USE ONLY *(Required)*

EFFECTIVE DATE	ACCOUNT NUMBER	BRANCH NAME	BRANCH CODE	ER AAE

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