FLEXIBLE SPENDING ENROLLMENT

☐ New enrollment ☐ Mid-year change ☐ Open enrollment

##62T02113##################

A. PARTICIPANT INFORMATION (REQUIRED–COMPLETE IN FULL)

Employee name: _____ DMBA ID number: _____

Employer name: _____ Email: _____

B. FLEXIBLE SPENDING ELECTIONS

☐ HEALTHCARE ACCOUNT OR LIMITED PURPOSE ACCOUNT*

Total Annual Election $

Annual maximum = **$3,400**

* Healthcare accounts are for participants enrolled in DMBA PPO 90, DMBA PPO 70, Life and Disability only, or who have waived all benefits are eligible. Limited purpose account are for participants enrolled in DMBA HSA 80 or DMBA HSA 60.

☐ DEPENDENT CARE ACCOUNT**

Total Annual election $

Annual maximum: Married, filing separately = **$3,750** a year.
Others = **$7,500** a year. Cannot be more than your earned income or your spouse's earned income, whichever is less.

** All participants may open a dependent care account, regardless of plan enrollment.

C. MID-YEAR CHANGE IN FAMILY STATUS (PLEASE EXPLAIN)

Date of change in family status: _____

☐ Change in marital status: _____

☐ Change in dependent status: _____

☐ Change in work status: _____

D. ACCOUNT TYPE ELIGIBILITY

HEALTHCARE FSA: If you are enrolled in DMBA PPO 90, DMBA PPO 70, Life and Disability only, or have waived all benefits, you may open a healthcare FSA. Account funds may be used for eligible medical, dental, prescription, and vision expenses.

LIMITED PURPOSE FSA: If you are enrolled in enrolled in DMBA HSA 80 or DMBA HSA 60, you may open a Limited-Purpose FSA (LPFSA). Account funds are limited to reimbursements for eligible dental and vision expenses.

To learn more about eligible expenses, log in to www.dmba.com to view the *FSA/LPFSA/HSA Eligibility List* or refer to IRS Publication 502.

E. PARTICIPANT AUTHORIZATION (REQUIRED)

I choose to be reimbursed from my Flexible Spending Account(s) for qualified expenses according to plan guidelines for claims submission. I understand the total annual elections indicated above will be withheld in equal increments from each paycheck throughout the plan year. If my total annual election exceeds my actual substantiated expenses, I understand I forfeit the excess to my employer. I release my employer from all present and future rights or

claims to any sums reduced from my paycheck and used for payment of expenses through my Flexible Spending Account(s). I understand my total annual election amount and my participation during the plan year may only be changed because of a change in family status. I understand mid-year changes to my Flexible Spending Account(s) must be consistent with my change in family status and must be made within 60 days of the change. I understand I may not decrease my election to less than the amount already in my account(s). I accept responsibility for proper income tax reporting in regard to benefits reimbursed by this plan.

I understand if I do not substantiate a claim when requested, my DMBA Benefits Card (account debit card) may be suspended until the transaction is refunded or resolved. I also understand DMBA health plan claims may be used to automatically offset any balance due. This process will occur throughout the year.

Signature: _____ Date: _____

Please return this completed form to enrollmenthelp@dmba.com. You may also mail it DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.