Advantage™ ADMINISTRATORS

PARTICIPATION FORM FOR THE FLEXIBLE BENEFITS PLAN

Name _____ Social Security No._____
Employer_____ Date of Birth_____
Home Address_____City_____State_____ Zip_____

Optional Reimbursement Services: Reimbursements are sent by check unless otherwise noted below.
E-mail (required for direct deposit and debit card users): _____

☐ YES I want the convenience of direct deposit for my plan reimbursement. I hereby authorize Advantage Administrators to initiate deposits to my ☐ checking account or ☐ savings account as indicated below.
Please be sure to write your numbers clearly on the form or attach a voided check. Notification of deposits will be sent by E-mail.

Routing Number: _____ Bank Account Number: _____

☐ YES I want the convenience of using the flex debit card to pay qualified expenses. I understand that two flex debit cards will be provided, both in my name, at no charge; the second card can be signed and used by my spouse or dependent.

Debit Card Agreement: I understand that the flex benefits card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the flex benefits card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if payment is made that it is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

OPTION 1 HEALTHCARE FLEXIBLE SPENDING ACCOUNT

☐ YES I elect to contribute $_____ annually (before taxes) for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified out-of-pocket health care expenses not covered by my health or other insurance plans.

☐ *Either myself or my spouse has a High Deductible Health Plan (HDHP)) and intend to make contributions to a Health Savings Account (HSA), a tax exempt bank account that can be used to pay for eligible medical expenses. If this box is checked, please consider the options below:*

☐ This is a Limited Purpose Account and does not apply to expenses other than Dental and Vision.
☐ This election does not apply to expenses incurred by my spouse.

☐ NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 DEPENDENT CARE BENEFIT ACCOUNT

☐ YES I elect to contribute $_____annually (before taxes) for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified dependent care expenses.
☐ NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 3 AGREEMENT TO SAVE TAXES ON INSURANCE PREMIUMS

☐ YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my election will automatically be adjusted to reflect that change.
☐ NO I decline this option for this plan year and understand I will lose all tax savings that I could receive as a participant.

ADDITIONAL BENEFIT (please insert description provided by your HR Department, if applicable) _____

☐ YES I elect to contribute $_____annually(before taxes) for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified expenses.
☐ NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read and understand the Summary Plan Description. I have also read and understand the Important Information on the back of this brochure.

Employee Signature_____ Date_____

To be completed by employer:
Effective Date if not renewal (mm/dd/yy) ___/___/___First payroll date ___/___/____ Number of Payrolls for deduction _____

Flex Benefit Plan WORKSHEET

Visit www.advantageadmin.com for a list of covered items

Now that you know about the many ways you can use pre-tax earnings to keep more of what you earn, take a moment to fill out this worksheet to determine how much money you'll save annually by participating in your employer's flex benefit plan.

Simply check off the items you wish to save for and budget how much you'll spend in the upcoming year on those products and services. Fill in the estimate in the space next to each item. Then add up each category and place those totals in the corresponding section below the checklist.

HEALTHCARE EXPENSES (estimated)

FOR EXPENSES NOT COVERED BY INSURANCE

- ❑ Co-pays to doctors & pharmacies $ _____
- ❑ Oxygen, insulin, syringes & supplies $ _____
- ❑ Dual Purpose Items (Letter of Medical Necessity is needed in order for these items to be flex eligible) $ _____
- ❑ Special schooling for disabled child $ _____
- ❑ Prescription drugs $ _____
- ❑ Wigs for hair loss caused by disease $ _____
- ❑ Office visits & checkups $ _____
- ❑ Reconstructive surgery (birth defect, disease) $ _____
- ❑ Prescribed sunglasses & eyeglasses $ _____
- ❑ Medical alert bracelet & fees $ _____
- ❑ Contact lenses, solutions & supplies $ _____
- ❑ Alcoholism & drug treatment $ _____
- ❑ Eye exams, surgery & LASIK $ _____
- ❑ Quit-smoking program & medications $ _____
- ❑ Dental cleanings, fillings & x-rays $ _____
- ❑ Weight-loss program (prescribed by doctor) $ _____
- ❑ Sealants, crowns, bridges & dentures $ _____
- ❑ Walkers, canes & wheelchairs $ _____
- ❑ Braces, spacers & retainers $ _____
- ❑ Arches & orthopedic shoes $ _____
- ❑ Wisdom teeth, implants & oral surgery $ _____
- ❑ Artificial limbs & braces $ _____
- ❑ Psychologist & psychiatrist fees $ _____
- ❑ Physical & speech therapy $ _____
- ❑ Obstetrics & fertility $ _____
- ❑ Hearing aids, batteries & exams $ _____
- ❑ Lab tests & body scans $ _____
- ❑ Chiropractic & podiatrist fees $ _____
- ❑ Travel & mileage to doctor or hospital, etc. $ _____
- ❑ Misc/Other $ _____

TOTAL OPTION 1 $ _____

DEPENDENT CARE EXPENSES (estimated)

SO YOU CAN WORK

- ❑ Nanny & babysitter $ _____
- ❑ Day camp $ _____
- ❑ Pre-K or nursery school $ _____
- ❑ Daycare for a disabled adult or child $ _____
- ❑ Before & after-school care $ _____
- ❑ Elder daycare for parent or dependent $ _____

TOTAL OPTION 2 $ _____

ESTIMATED ANNUAL EXPENSES AND TAX SAVINGS

TOTAL 1 _____ + **TOTAL 2** _____ + Other _____ = $_____

Save between 25% and 40% on FICA, federal & state income tax (in applicable states). **x 36%**

Based on national averages, you'll save 25% if your annual household earnings are less than $30,000, 36% if you earn $30,000 to $60,000, or 40% if you earn more than $60,000.

Federal and/or plan limits apply to all options. See your summary plan description for plan limits.

YOU SAVE $ _____