



Premier Benefits Solutions
P.O. Box 1878, Tallahassee, FL 32302-1878

State of Ohio FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Health Care and/or Dependent Care Spending Account.

For Open Enrollment Only: You may enroll online at www.myFBMC.com

Name (Please Print) Last		First	MI	Employee ID #	
Home Address Street		City	State	ZIP	
Daytime Phone ()	Home Phone ()	Date of Hire	Date of Birth	Annual Salary	
E-mail Address					
ENROLLMENT STATUS: <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> RE-ENROLLMENT <input type="checkbox"/> CHANGE IN STATUS <input type="checkbox"/> NEW HIRE					
CHANGE TYPE: _____ DATE: ____ / ____ / ____					

- Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
- Health Care and Dependent Care Spending Account worksheets are available at www.myFBMC.com as well as at <http://das.ohio.gov/flexiblependingaccount>.
- If you have questions, consult your Flexible Benefits Plan Open Enrollment Brochure, or call **FBMC Customer Care Center at 1-800-342-8017**.
- Your effective date will be the first of the month after FBMC receives your enrollment form. Plan Year effective date is January 1, 2011.

In Box #1, indicate the dollar amount you elect to contribute for the 2011 plan year.

In Box #2, indicate the number of regular payroll checks from which deductions will be taken during the 2011 plan year.

In Box #3, indicate the deduction amount per paycheck. (**Note:** If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.)

By signing this form you certify that you expect to receive the number of paychecks listed in Box #2. If appropriate, decrease the number to allow for anticipated unpaid leave, or for planned retirement, or any other anticipated leave.

HEALTH CARE SPENDING ACCOUNT	
Use your Health Care Spending Account for eligible uninsured, out-of-pocket medical expenses incurred by you, your family members or both. (Annual allowable maximum contribution per participant is \$3,000)	
Box #1	Total plan year dollar amount from your worksheet _____
Box #2	24 for employees paid bi-weekly 12 for employees paid monthly ÷ _____
Box #3	Reduction per regular paycheck = _____

DEPENDENT CARE SPENDING ACCOUNT	
TAX FILING STATUS— PLEASE CHECK ONE:	
<input type="checkbox"/> Married, filing separately [maximum - \$2,500]	<input type="checkbox"/> Married, filing jointly [maximum - \$5,000]
<input type="checkbox"/> Single, head of household [maximum - \$5,000]	
Box #1	Total plan year dollar amount from your worksheet _____
Box #2	How many consecutive pay periods for payroll deduction? _____
Employees paid bi-weekly (max of 24)	
Employees paid monthly (max of 11) ÷	_____
Box #3	Reduction per regular paycheck = _____

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before Medicare, local, state and federal income taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any Spending Account not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one Spending Account cannot be used to reimburse expenses covered by another Spending Account.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment before the end of the plan year or file an approved Change In Status Election Form with the contract administrator within 30 days of the event.
- I understand that the funds in any Spending Account can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any Spending Account or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I certify that: 1) I will only use my Spending Account to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my Spending Account, 3) I will not seek reimbursement through any additional source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	DATE SIGNED
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SUBMIT YOUR COMPLETED FORM TO FBMC AT P.O. BOX 1878, TALLAHASSEE, FL 32302-1878 OR FAX TO (850) 514-5806.

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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