



Flexible Spending Account (FSA) Enrollment Form

I. Account Holder Profile Information

First Name:		Last Name:		SSN:
Date of Birth:		Email Address:		
Mailing Address Line 1:				
Mailing Address Line 2:				
City:		State:		Zip:
Home Phone:			Cell Phone:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single			Employer:	

II. Election

I authorize my employer to make the following pre-tax deductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event such as marriage, divorce, death, or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn't eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck.

Effective Date:		1 st Payroll Deduction Date:	
Number of Payrolls this plan year: <input type="checkbox"/> 52 <input type="checkbox"/> 26 <input type="checkbox"/> 24 <input type="checkbox"/> 12 <input type="checkbox"/> Other # _____			
Healthcare Standard FSA	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____	
Healthcare Limited FSA <i>(Only if enrolled in a HSA)</i>	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____	
Dependent Care Account	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____	

III. Direct Deposit Setup

Bank Name: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Account Number:		
Routing Number:		
Address:		
City:	State:	Zip:

JON SMITH 1234 8th ST. S. FARGO, ND 58102		1200
DATE _____		
PAY TO THE ORDER OF _____ \$ _____		
MEMO _____		
<div style="display: flex; justify-content: space-between;"> ⑆012345678⑆ ⑆68590134⑆ ⑆200 </div>		
Routing Number Account Number		

IV. Debit Card

A Debit Card will automatically be issued in the account holders name and shipped to the address above. Once the enrollment is processed it should arrive within 10-14 days.

Note: To issue separate debit cards to any dependents 18 years of age or older, please complete the following section.

Name:	DOB:	SSN:	Relationship:
Name:	DOB:	SSN:	Relationship:

V. Authorization

Signature _____ Date _____	Employer Authorization: _____
**Please be sure to return this form to your employer for approval. **	



Healthcare Flexible Spending Account (FSA)

SAVE MONEY WHILE KEEPING YOU AND YOUR FAMILY HEALTHY

Why enroll in a Healthcare Flexible Spending Account?

- Save an average of **30%** on a wide variety of eligible healthcare expenses by paying for them on a **pre-tax basis**
- No waiting—access the full amount of your annual election on the first day of your plan year
- Save time—choose from several convenient, hassle-free payment and reimbursement options.



How Does the FSA Work?

You chose to enroll in the FSA through your employer, which is administered by HRCTS. Complete the election form indicating how much you would like to withhold from your payroll on a pre-tax basis. HRCTS sends you a VISA debit card preloaded with your full election amount to pay for qualified medical, dental, and vision expenses during the FSA Plan Year. You save money by putting the funds away pre-tax, and you have the entire election available to you on day one to help cover out-of-pocket healthcare expenses for you, your spouse, and eligible tax dependents.

Examples of Eligible Expenses

- **Medical** – deductibles, co-pays, co-insurance, diagnostic tests, lab work, chiropractic care
- **Dental** – orthodontia, x-rays, fillings, sealants, crowns, root canals, and dentures
- **Vision** - contacts, glasses, Lasik eye surgery, prescription sunglasses and contact lens solution
- **Prescriptions** - all prescriptions are covered
- **Over-the-Counter** – medications, first aid supplies, hearing aids, orthopedic inserts, thermometers, menstrual products and sunscreen

** Treatments for cosmetic reasons are not covered.*

** Some services/purchases need to have a letter of medical necessity to be eligible.*

** You can access an updated list of eligible expenses at: <http://expenses.hrcts.com>*

** Please note this list of eligible expenses is subject to change according to the IRS Regulations.*

How Do I know How Much to Elect?

You may elect up to the employer's designated maximum, not to exceed the IRS maximum. However, we have provided you with an expense worksheet to help you calculate how much you should put away pre-tax per year. You then take the total amount you wish to elect for the year, and divide it by the number of payrolls your company has in a year, and this determines your payroll deduction.

This money comes out before you pay Federal Tax, FICA Tax, and State Tax.

When you add up your tax savings with your money in this account, you have effectively increased your take home pay.





Healthcare Flexible Spending Account (FSA)

How Do I Access My Funds?

There are two ways for you to access the funds in your Flexible Spending Account!

- **VISA Debit Card** – HRCTS will provide you with a smart debit card, which you can use to pay for eligible expenses such as prescriptions, co-pays, over the counter items, and so much more. When you are at a provider or a merchant with an IIAS (Inventory Information Approval System), you simply swipe your card and it will deduct the eligible expenses from your account. Always keep a receipt of payment to verify the expense.
- **Submit a manual claim** – You can also submit a claim online, via fax, mail, or mobile app, as long as you attach an itemized receipt showing the eligible expense. Receipts are required in order to process claims, and must have service date/purchase date, description of service/item purchased, name of provider/merchant, and the expense amount.



Please refer to your plan documents regarding how funds are handled at the end of the plan year. You have 90 days after the plan year ends to submit for expenses which were incurred in the plan year.

CALCULATE HOW TO SAVE BELOW!

You can use this worksheet to estimate how much you will need to put into your FSA. Please be conservative and don't forget that this account covers you, your spouse, and eligible dependents.

Health Care Expenses	You	Your Spouse	Other Dependent(s)
Deductibles			
Medical	\$ _____	\$ _____	\$ _____
Dental	\$ _____	\$ _____	\$ _____
Vision	\$ _____	\$ _____	\$ _____
Co Pays			
Medical	\$ _____	\$ _____	\$ _____
Dental	\$ _____	\$ _____	\$ _____
Dental Care	\$ _____	\$ _____	\$ _____
Prescriptions	\$ _____	\$ _____	\$ _____
Vision Care			
Eye Exams	\$ _____	\$ _____	\$ _____
Glasses	\$ _____	\$ _____	\$ _____
Contacts	\$ _____	\$ _____	\$ _____
Chiropractic and/or Acupuncture	\$ _____	\$ _____	\$ _____
Other Eligible Expenses	\$ _____	\$ _____	\$ _____
Total Estimated Expenses	\$ _____	\$ _____	\$ _____
Total Annual Election	Add above lines together. \$ _____		
Total Annual Election ÷ Total # Pay Periods = Payroll Deduction			
\$ _____ ÷ _____ = \$ _____			

Save an average of **30%** on a wide variety of eligible healthcare expenses
by paying for them on a **pre-tax basis!**



Dependent Care Flexible Spending Account (DCA)

IT'S YOUR MONEY SO WHY NOT KEEP MORE OF IT?

Your Estimated Tax Savings			
WITHOUT Dependent Care FSA		WITH Dependent Care FSA	
Gross Annual Pay	\$60,000	Gross Annual Pay	\$60,000
Average Tax Rate (30%)	- \$18,000	Max Annual DCA Contribution (PRE-TAX DEDUCTION)	-\$5,000
Net Annual Pay	= \$42,000	Adjusted Gross Pay	= \$55,000
Annual Dependent Care Expense	-\$5,000	Average Tax Rate (30%)	- \$16,500
Final Take Home Pay	= \$37,000	Final Take Home Pay	\$38,500
TAKE HOME THIS MUCH MORE WITH A DEPENDENT CARE FSA			\$1,500

All figures in this table are estimates, and based on an annual salary of \$60,000 and maximum contributions to the benefit account. Your salary, tax rate, dependent care expenses, and tax savings may be different.

How Does a Dependent Care Account Work?

A DCA is a pre-tax saving account which the IRS allows you to put funds into. You can then use these funds for qualified dependent care expenses, such as **preschool, summer day camp, before or after school programs, and child or adult daycare**. You may choose to enroll in the DCA through your employer, which is administered by HRCTS. Complete the election form indicating how much you would like to withhold from your payroll on a pre-tax basis. It is a smart, simple way to save money while taking care of your loved ones so you can continue to work.



SAVE money, while
caring for the ones you
LOVE!

Guidelines

**You must follow the guidelines set below in order for your dependent care expense to be eligible for reimbursement.*

1. Dependent care expenses cover qualified dependent children 12 or younger, or a spouse/tax dependent who is mentally or physically incapable of caring for themselves.
2. Dependent care expenses incurred must allow a single parent or both married parents to be gainfully employed or attend school full time during the time the child is being taken care of.
3. Your dependent must live in your home for at least 8 hours each day.
4. Any day care center or program must meet the state and local requirements in order to be eligible.
5. A babysitter can watch the dependent inside or outside the home, as long as the sitter is at least 19 years of age, and is not your spouse or someone you claim on your tax return as a dependent.



Dependent Care Flexible Spending Account (DCA)

How Do I Access My Funds?

There are two ways for you to access the funds in your Dependent Care Account!

- **VISA Debit Card** – HRCTS will provide you with a smart debit card which you can present at the day care facility you use if they accept credit cards as a form of payment. Always keep a receipt of payment to verify the expense. *You can only use your card for the amount you have in your account.*
- **Submit a manual claim** – You can also submit a claim online, via fax, mail, or mobile app. You can submit your claim three ways.
 - Submit a completed claim form with your provider's signature. (no receipt required)
 - Submit one claim form with your provider's signature or receipt at the beginning of the year for the whole year if you have the same expense all year.
 - Submit a completed claim form with an itemized receipt including: service start and end date, description of service, provider, expense amount, tax ID #, and the dependent receiving the service.



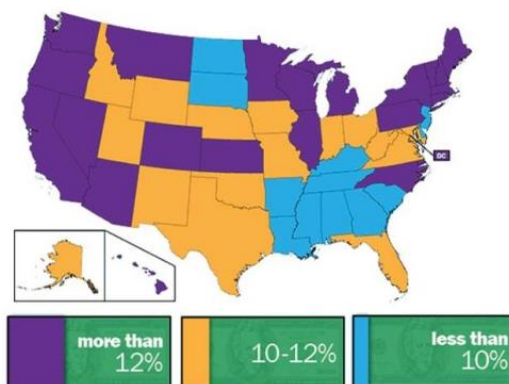
CALCULATE HOW TO SAVE BELOW!

You can use this worksheet to estimate how much you want to elect into your DCA.

Weekly Dependent Care Expenses	
Preschool	\$ _____
Daycare	\$ _____
Babysitting	\$ _____
After School Program	\$ _____
Before School Program	\$ _____
Custodial/Adult Care	\$ _____
Disabled spouse/Dependent Care	\$ _____
Total Estimated Weekly Expense	\$ _____
Total Weekly Election x 52 = Annual Election \$ _____ x 52 = \$ _____	
Annual Election ÷ # Pay Periods = Payroll Deduction \$ _____ ÷ _____ = \$ _____	

Average Cost for an Infant in a Center

As a % of a Married Couple's Median Income



Source: Parents and the High Cost of Child Care: 2013 Report

The amount you put into an DCA is called an "election," and your election cannot be more than the maximum amount set by the IRS. Currently, the maximum amount is \$5,000 each plan year. There is also a \$5,000 maximum per family per calendar year. However, if you're married and file separate tax returns, the maximum is \$2,500.



FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM AND RECEIPT SUBMISSION

To complete a Flexible Spending Account reimbursement request (a claim), you have the following options:

There are two reimbursement options.

1. Pay out-of-pocket and submit for reimbursement using the claim form and provide a receipt. The claim can be submitted via mail, fax, email, mobile app, or online via the participant portal.
2. Pay with your FSA debit card and submit an itemized receipt or Explanation of Benefits (EOB) as substantiation.

Completing a Universal Claim Form:

- Submit a claim form with an itemized receipt or EOB to substantiate the purchase.
- The claim form must be completed entirely, dated, signed and must have the following five pieces of information to be accepted for processing.
 1. Claim Code F – corresponding to the FSA
 2. Service Date or Purchase Date (if payment is for an eligible item, and not a service)
 3. Description of Service (prescriptions, copay, office visit, glasses, etc.)
 4. Provider (the name of the merchant or provider who performed the service)
 5. Claim Amount (the total amount for the service)

1 F Claim Code	2 February 14, 2017 Start Date of Service	February 14, 2017 End Date of Service	4 Walgreens Provider
	3 Prescription Description of Service		5 15.00 Claim Amount
	Chandler Bing Person Receiving Service (Required for HRA)	Tax ID (Dependent Care FSA only)	Daycare Provider Signature (Dependent Car

Note: Please sign the bottom of the claim form authorizing HRCTS to process the claim.

Substantiating a Purchase:


If you have made a purchase using your FSA debit card, you may be required to substantiate your purchase. The purpose of this is to ensure the purchase was FSA-eligible and to keep you in compliance with all IRS regulations.

If you receive communication from HRCTS requesting a receipt for a purchase please ensure your receipt follows the necessary guidelines and has all the information required to process. HRCTS will request the receipt from you one time.



Example of Acceptable Substantiation:

Required Information	
1. Provider Name	1 → ABC Eye Associates
2. Date of Service	01-25-2001 ← 2
3. Description of Service	3 → (999) 555-1111 CUSTOMER RECEIPT
4. Claim Amount	



Customer Name: SARA SAMPLE	
Frames: 1 Set	\$125.00
Lenses: anti-glare, scratch proof	\$ 79.00
Subtotal:	\$204.00
Tax:	\$ 12.24
TOTAL:	\$216.24 ← 4
ABC Eye Associates * 123 Maple Street * Somewhere * CT * 99999	

Please Note: HRCTS has a receipt form which can be used to collect the required information, if you cannot obtain an itemized receipt

When will HRCTS ask me for a receipt?

Depending on the location in which your FSA debit card was used, HRCTS may require a receipt. Generally this is done because the location where you made the purchase provides both eligible and non-eligible services under the IRS Guidelines.

The most common receipt requests will be for dental and vision expenses.

What will happen to my claim if my receipt does not have all the required information?

Upon receiving your claim, HRCTS will review to ensure all required information is on both the claim form and the receipt.

If information is missing, HRCTS will reach out to you requesting more Information, which allows you to collect the missing data and submit to HRCTS to finish processing your claim.

If we still do not receive all the required information, then we will deny the claim.





Is my Credit Card Slip showing I paid for services acceptable?

No, your credit card slip will not be acceptable as a receipt.

The reason for this is a credit card receipt only shows the date in which you PAID for the service, and the amount you paid. It does not show the **date of service or description of service**.

A payment for a service may be made before or after the date of service, and HRCTS must ensure all expenses are incurred within the plan year to be eligible for reimbursement.

Contact Customer Service: Monday – Friday 8: 30am-7:30pm EST

 (603) 647-1147 Option 1  (866) 978-7868  customerservice@hrcts.com  LiveChat



DEPENDENT CARE ACCOUNT (DCA) CLAIM AND RECEIPT SUBMISSION

To complete a Dependent Care Account reimbursement request (a claim), you have the following options:

There are two reimbursement options.

1. Pay with your DCA debit card and submit an itemized receipt for substantiation.
2. Pay out of pocket and submit for reimbursement using the claim form with the provider's signature. The claim can be submitted via mail, fax, email, mobile app, or online via the participant portal.

Completing a Universal Claim Form:

- Submit a claim form using code "D" for DCA claim.
- When the claim form is signed by your provider, it serves as substantiation.
- The claim form must be completed entirely, and must have the following information to be accepted for processing:
 1. Service Date (start date & end date)
 2. Description of Service (ex: daycare, summer camp, after school care, adult daycare)
 3. Provider (the name of the merchant or provider who performed the service)
 4. Claim Amount (the total amount for the service)
 5. Tax ID # (or Social Security Number, if the provider does not have a Tax ID)
 6. Signature of Provider

D Claim Code	1 8/10/2016 Start Date of Service	8/10/2017 End Date of Service	3 Sally Fields Provider
	2 Day Care Description of Service		4 \$400.00 Claim Amount
	Tracy Smith Person Receiving Service (Required for HRA)	5 04*0044554 Tax ID (Dependent Care FSA only)	6 [Signature] Daycare Provider Signature (Dependent Care FSA only)

Note: Please sign the bottom of the claim form authorizing HRCTS to process the claim.

SUBMIT ONE CLAIM FORM FOR THE ENTIRE YEAR!

YES! You can submit one claim form for the entire elected amount at the start of the plan year.

Complete the claim form with the start and end date of the service. Then in the claim amount box, submit for the full elected amount.

Once received, HRCTS will review to ensure the form is complete with all required information. Once approved, you will then receive payment directly to you via check or direct deposit in the exact amount withheld from payroll.



Submitting an Itemized Receipt:

If you are submitting a claim form with an itemized receipt (Option 2), please ensure the receipt has the required information below.

Example of Acceptable Substantiation:

Required Information								
1. Date of Service	<table border="1"><thead><tr><th>Dates</th><th>Service Type</th><th>Amount</th></tr></thead><tbody><tr><td>January 4-8, 2001</td><td>Daily Child Care, toddler group</td><td>\$ 375.00</td></tr></tbody></table>		Dates	Service Type	Amount	January 4-8, 2001	Daily Child Care, toddler group	\$ 375.00
Dates			Service Type	Amount				
January 4-8, 2001			Daily Child Care, toddler group	\$ 375.00				
2. Description of Service								
3. Provider's Name								
4. Claim Amount								
5. Tax ID #								
6. Person receiving the service								

Note: No additional documentation is required if all 5 items are included on the receipt/documentation from the provider.

Example of an Unacceptable Substantiation:

Required Information	Receipt Missing Information
1. Date of Service MISSING	<p>Happy Kids Day Care 125 Main Street Smallville, CA 12345 (999) 555-1313</p> <p>DATE: 01-08-2001 TIME: 05:43PM</p> <p>ITEM: 0041 VIS SALE ACCT: XXXXXXXXXXXX9876 AUTH: 9898</p> <p>TOTAL: \$375.00</p> <p>I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO CARD ISSUER AGREEMENT (MERCHANT AGREEMENT IF CREDIT VOUCHER)</p> <p>x _____</p>
2. Description of Service MISSING	
3. Providers Name	
4. Claim Amount	
5. Tax ID # MISSING	
6. Person receiving the service MISSING	

Contact Customer Service: Monday – Friday 8:30am-7:30pm EST



(603) 647-1147 Option 1



(866) 978-7868



customerservice@hrcts.com



LiveChat



SET UP YOUR ONLINE ACCOUNT

Go to our Online Account Setup page <http://hrcts.com/setup> for instructions on retrieving your username, creating an account password, and entering new user security questions to complete your online account profile.



Note: Your online account will be available to you **within 30 days** of your plan effective date.

If you already have an account you can login directly from <https://employee.hrcts.com>

TROUBLE ACCESSING YOUR ACCOUNT?

1. Your password must be a minimum of six characters, and is case sensitive.
2. When resetting your password, the answers to your security questions are case sensitive.
3. Password History: Your password must not be one of your last 12 passwords used.
4. Account Inactivity: After 180 days of inactivity, you must follow the password reset process in order to access your account again.

HRCTS MOBILE APP:

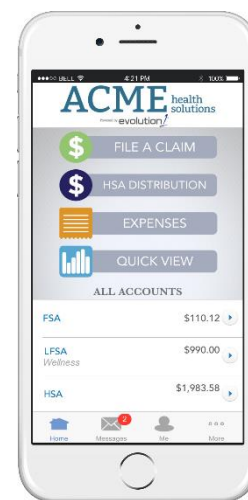
Download the **HRC Total Solutions App** and check your balance and final filing date, submit claims, and upload receipts on any Android or iOS device.

View all claims requiring receipts, and submit new receipts by taking a picture with your mobile device.

SMS TEXT ALERTS

SMS text message alerts are available for all mobile devices on AT&T, Sprint, Verizon, US Cellular and T-Mobile networks! You can opt in/out via the [Consumer Portal](#) and configure which alerts you prefer to receive by selecting "Update Notification Settings" under the Statements & Notifications tab. Some alert options include:

✓ Claim Confirmation	✓ Receipts Needed for Debit Card Transaction
✓ Claim Denial	✓ Receipt Reminder
✓ HSA Account Summary	✓ Expense Notification



AUTOMATIC PHONE SYSTEM

- You can access your available balance, final filing date, final service date, eligible amount, and your most recent transactions all from a toll-free automated phone service!
- This service is available 24/7 to all participants enrolled in an FSA, DCA, HRA, or HSA plan. Just select option 6 when calling HRCTS, or you can reach this service directly by calling (877) 415-8093.
- You will need to have a phone number on file in your online account, along with your ZIP code, in order to use this service.



Flexible Spending Account (FSA) Enrollment Form

I. Account Holder Profile Information

First Name:		Last Name:		SSN:
Date of Birth:		Email Address:		
Mailing Address Line 1:				
Mailing Address Line 2:				
City:		State:		Zip:
Home Phone:			Cell Phone:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Employer:	

II. Election

I authorize my employer to make the following pre-tax deductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event such as marriage, divorce, death, or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn't eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck.		
Effective Date:		1 st Payroll Deduction Date:
Number of Payrolls this plan year: <input type="checkbox"/> 52 <input type="checkbox"/> 26 <input type="checkbox"/> 24 <input type="checkbox"/> 12 <input type="checkbox"/> Other # ____		
Healthcare Standard FSA	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____
Healthcare Limited FSA <i>(Only If enrolled in a HSA)</i>	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____
Dependent Care Account	Employee Annual Election: \$ _____	Per Pay Period Election: \$ _____

III. Direct Deposit Setup

Bank Name: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Account Number:		
Routing Number:		
Address:		
City:	State:	Zip:

JON SMITH 1234 8th ST. S. FARGO, ND 58102		1200
DATE _____		
PAY TO THE ORDER OF _____ \$ _____		DOLLARS
MEMO _____		
⑆0⑆2345678⑆⑆68590134⑆⑆		⑆200
Routing Number		Account Number

IV. Debit Card

A Debit Card will automatically be issued in the account holders name and shipped to the address above. Once the enrollment is processed it should arrive within 10-14 days.			
Note: To issue separate debit cards to any dependents 18 years of age or older, please complete the following section.			
Name:	DOB:	SSN:	Relationship:
Name:	DOB:	SSN:	Relationship:

V. Authorization

Signature _____ Date _____	Employer Authorization: _____
**Please be sure to return this form to your employer for approval. **	

Don't know how to spend your **FSA money?**

Did you know you could use your FSA to save money on everyday health essentials like baby health items, health trackers, pain relief products and more?

Use your FSA funds or risk forfeiting your money.



The largest selection
of guaranteed
FSA-eligible products



24/7 support,
FREE shipping on
orders over \$50



**Are your health
needs eligible?**
Easily check with our
expansive Eligibility List



Need an Rx?
We'll work with you to
make getting one easier



Learning Center
Get daily money-
saving info



Use your FSA card
or any major credit card

\$10 OFF

One use per customer

Want 10 bucks to spend on your health?

Visit **FSAstore.com/FlyerHRCTS** and
use code **FCHRCTS10** at checkout.