RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS MID-YEAR CHANGE/ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

A. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

HOME ADDRESS	City	STATE	ZIP CODE

DEPARTMENT NAME	DEPT ID/BUDGET CODE	WORK PHONE	EDISON ID

B. ENROLLMENT OR CHANGE REQUEST

GENERAL MEDICAL FSA (FSA)	LIMITED PURPOSE FSA (L-FSA)	DEPENDENT CARE FSA (DC-FSA)
❑ Terminate contributions	❑ Terminate contributions	❑ Terminate contributions
❑ Start account with the following annual contribution amount: $_____	❑ Start account with the following annual contribution amount: $_____	❑ Start account with the following annual contribution amount: $_____
❑ Change existing annual contribution amount to: $_____	❑ Change existing annual contribution amount to: $_____	❑ Change existing annual contribution amount to: $_____

Note: The plan will determine how much to deduct from each paycheck based on the amount already contributed for the year and the number of pay periods remaining in the year. No mid-year change in election amount may be less than the amount the employee has previously contributed through payroll contributions in the Plan Year, or less than the amount the employee has been reimbursed for eligible expenses for the Plan Year.

If you are enrolled in the CDHP/HSA, you are not eligible to contribute to the General Medical FSA; however, you may contribute to the Limited Purpose FSA (for vision and/or dental expenses only).

C. PERMISSIBLE MID-YEAR CHANGE IN STATUS – All requests must be received within 60 days of the change in status event

Mid-year enrollment or changes to FSA, L-FSA, and DC-FSA elections are only permissible if the Participant or Eligible Employee has a change in status that affects eligibility for FSA participation (an individual may experience a status change event that permits a mid-year election change in their health plan coverage that does not affect FSA eligibility), AND the new election is consistent with the status change.

CHANGE IN STATUS EVENTS	REQUIRED DOCUMENTATION
❑ Marriage	Copy of marriage certificate
❑ Divorce or legal separation	Copy of divorce decree or legal separation paperwork signed by judge
❑ Birth	Copy of birth certificate
❑ Adoption / placement for adoption	Copy of adoption documents
❑ Change of employment status that affects eligibility (includes part to full time / full to part time)	Documentation to substantiate the change in employment status from the relevant employer
❑ Entitlement to Medicare, Medicaid, CHIP	Letter of entitlement from Medicare or Medicaid or copy of new ID card
❑ Loss of eligibility for Medicare or Medicaid, CHIP	Letter of loss of eligibility from Medicare or Medicaid
❑ National Medical Support Notice	Copy of National Medical Support Notice
❑ Death (employee, spouse or dependent)	Death certificate — not necessary if shows in Edison
❑ Gain or Loss of Dependent or Qualifying Individual status	Documentation to substantiate the gain of status / attestation of loss of status
❑ DC-FSA only: Change of provider resulting in a significant cost increase or decrease	Documentation from a new, non-relative provider that substantiates the change of cost
❑ DC-FSA only: Change of DC-FSA election of spouse or former spouse under their employer's plan (i.e. open enrollment)	Documentation from spouse or former spouse's employer to substantiate the DC-FSA election change and date of election change

Continue to page 2 to complete and sign the change request.

You **MUST** explain on the space below why your requested change is consistent with your status change. An election change is consistent only if the election change is necessary or appropriate as a result of the status change event. All change requests are subject to approval by Benefits Administration for compliance with the State Plan Document and IRS rules. BA may require further information or documentation.

D: AUTHORIZATION

- I confirm that the information above is true, and I understand that all requests are subject to review and approval by BA for compliance with federal rules and the State Plan Document. I agree to provide further information or documentation upon request from BA and understand that the deductions will begin on the first of the month following the submission of a completed request form with documentation.
- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- I hereby authorize my employer to reduce my gross salary before federal, state, and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect for the current plan year (to include termination of employment) unless I file a request for a mid-year change due to an approved status change event.
- I understand that any amount remaining in my Dependent Care account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year. I also understand that any funds in excess of $640 remaining in either the General Medical FSA or Limited Purpose FSA at the end of the year will be forfeited. Funds of $640 or less will carry over into the following year if I re-enroll.
- I understand and agree that the state will not incur any liability resulting from my participation in a flexible benefit or from my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.
- I understand that if I terminate employment during the plan year, I have 90 days from my termination date to submit claims for eligible expenses and that any claims submitted for reimbursement must be for dates of service on or prior to my termination date. Any funds left in my account(s) after the 90 days are forfeited.
- I acknowledge that FSA funds may only be spent on certain expenses. Medical Flexible Spending Account (FSA) and Limited Flexible Spending Account (L-FSA) debit card holders may be required to provide proof that expenses paid for with their debit card are covered expenses permitted by federal law and the FSA program. This is called "substantiation." The State's authorized contractor may send requests for substantiation to plan members.
- When a debit card expense is not substantiated, employers are required to recover the unsubstantiated expense through a number of mechanisms, including payroll deduction. FSA and L-FSA debit card holders must consent to payroll deductions from their wages to repay unsubstantiated expenses. Anyone who refuses to consent to these terms will not be allowed to enroll in the FSA or L-FSA.
- If I enroll in a Health FSA, I hereby agree that the State may deduct from my pay the amount of any expenses that remain unsubstantiated at the end of the runout period to the extent permitted by applicable law. This authorization of payroll deduction is a condition to participate in an FSA or L-FSA.

EMPLOYEE SIGNATURE	DATE

Return this application to your human resource office after making a copy for your records.

For questions regarding enrollment or a status change event, please call Benefits Administration at 615.741.3590 or 800.253.9981.

For questions regarding reimbursement requests, please call Optum Bank at 866.600.4984.