


# Archdiocese of Cincinnati 2010-11 Enrollment Form



 You will be making elections for the **July 1, 2010** through **June 30, 2011** Plan Year. After completing this form, please sign, date, and **return it to your Healthcare Administrator on or before May 17, 2010.** ***Please Note: Once Chard Snyder receives your Enrollment Form, you CANNOT change your Election Amount UNLESS you have a Qualifying Event.***

 If you have any questions, please contact your Healthcare Administrator or contact Chard Snyder at **(513) 459-9997**, toll free **(800) 982-7715**, or visit our **website at [www.chard-snyder.com](http://www.chard-snyder.com)**.

EMPLOYEE INFORMATION		
First Name	Home Phone ( ) -	
Last Name	Work Phone ( ) -	
SSN	Email Address	
Street Address		Apt#
City	State	ZIP
Pay Frequency (Check One) <input type="checkbox"/> Weekly (52 pays) <input type="checkbox"/> Monthly (12 pays) <input type="checkbox"/> Semi-Monthly (24) pays <input type="checkbox"/> Bi-Weekly (26)pays <input type="checkbox"/> Other		
Parish/School/Location Name:		

PLAN ELECTION DESCRIPTIONS	ELECT COVERAGE	ELECTION AMOUNTS
<b>Healthcare – Flexible Spending Account (FSA)</b> Out-of-pocket medical, dental and vision expenses. Contribute up to \$2400 for the plan year. (Min \$240 )	YES <input type="checkbox"/> NO <input type="checkbox"/> Waive coverage	Annual Election \$ _____
<b>Dependent Care – Flexible Spending Account (FSA)</b> Child and/or adult daycare expenses. If Single or Married filing jointly- Contribute up to \$5000 for the plan year. If Married filing separately-Contribute up to \$2500 for the plan year. (Min \$0)	YES <input type="checkbox"/> NO <input type="checkbox"/> Waive coverage	Annual Election \$ _____
<b>Direct Deposit (If selecting this option - ALL Bank Information Below is REQUIRED)</b> Used for Paper Claims sent to Chard Snyder for reimbursement directly to your personal bank account.  <b>Note: In the event that your direct deposit transaction is returned, Chard Snyder reserves the right to collect a \$25 processing fee.</b>  Bank <b>Nine</b> Digit Routing Number (Include ALL Zeros):  _____  Bank Account Number: _____ (Include All Zeros)  Bank Name: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>	Account Type: (Select One) <input type="checkbox"/> Checking <input type="checkbox"/> Savings

EMPLOYEE AUTHORIZATION	
I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all the authorizations & acknowledgements provided by Chard Snyder for each plan elected above on the second page of this form. I also acknowledge the receipt of the HIPAA Privacy Notice provided on the Chard Snyder website ( <a href="http://www.chard-snyder.com">www.chard-snyder.com</a> ).	
Signature	Date / /

CLIENT HR USE ONLY (MUST BE COMPLETED BY CLIENT HR IF SENDING IN PAPER FORMS FOR NEW HIRES)		
Employee Effective Date / /	Employee 1st Contribution Date: / /	HR Initials:

## EMPLOYEE ACKNOWLEDGEMENT & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate.

### FSA - ACKNOWLEDGEMENT & AUTHORIZATION:

#### I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Plan Year (as shown above). I must submit my claims, incurred during the Plan Year within the 90 day run-out period after the end of the Plan Year or the funds will be forfeited.
- I cannot change my mind once the Plan Year begins; my elections must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year to be considered for reimbursement (the date of service, not the date of invoice, must occur during the Plan Year).
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I understand that I am required to save all receipts for benefit card purchases in case I should be audited by the IRS. IRS suggestions are that I maintain records for 7 years.

I hereby authorize my employer to deduct from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I also acknowledge the receipt of the HIPAA Privacy Notice.

### DIRECT DEPOSIT - ACKNOWLEDGEMENT & AUTHORIZATION:

#### I understand that:

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and / or debit the same to such account.
- Direct deposit of my reimbursements shall commence within 4 weeks of receipt of this form.
- My direct deposit may be terminated per any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, or cancellation of direct deposit by my employer.

I hereby understand the information on this form and authorize Chard Snyder to complete my request.

### DEBIT CARD - ACKNOWLEDGEMENT & AUTHORIZATION (FSA AND/OR HRA ONLY):

#### I understand that:

- I have received, reviewed and understand the procedures of this debit card.
- Benefit card funds are authorized only for the payment of qualified expenses as outlined in my employer's plan document.
- The benefit card may be used only for eligible expenses at the point-of-service, and I may be required to submit a claim form with receipts and/or bills to Chard Snyder to substantiate the expense.
- I cannot itemize and deduct my out-of-pocket expenses again on my IRS Form 1040 for any accounts in which I am enrolled.
- I understand that I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.
- If I use my benefit card for ineligible expenses, I will be required to pay back the amount that was not covered by my plan.
- If I do not repay amounts used for ineligible expenses, my employer and/or Chard Snyder has the right to cancel my benefit card and deduct this amount from my salary.
- These funds have not or will not be reimbursed under any other plan coverage.
- I cannot include these expenses again when filing Form 1040 at year-end.
- Chard Snyder will not be held responsible for processing duplicate claims that I have submitted in error.
- The benefit card may not be accepted at all merchants that accept MasterCard/Visa.
- There is no cash access available for funds on the benefit card at any ATM.
- The benefit card must be returned upon demand.
- I have checked with my employer to verify the monthly fee, if any, to add to the benefit card.

I understand and agree to the terms and conditions specified on this form and authorize Chard Snyder to complete my request as indicated.