EMPLOYEE REIMBURSEMENT ACCOUNTS ENROLLMENT FORM

Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected.
Return the completed and signed form to your employer for processing.

Please indicate your current payroll center (if unsure, contact your HR/Benefits Specialist): ____ Central ____ Courts ____ Legislature ____ Univ. of WI ____ UW Hospital & Clinics ____ WHEDA ____ WEDC ____ Wiscraft Beyond Vision

For Employer to complete:

Employer Name: **STATE OF WISCONSIN**

Participant Plan Effective Date _____ Date of First Payroll _____

EMPLOYEE/PARTICIPANT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Date of Hire _____ Email Address (Personal Preferred)* _____

Home Phone Number* _____ Mobile Phone Number* _____

Home Address (street) _____

City _____ State _____ Zip Code _____

**Required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.*

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

I request the following amount(s) to be deducted pretax:		Employee Annual Salary Reduction Election Amount		IRS Contribution Limits
1	**Health Care FSA**	$		$2,550 per year
2	**Limited Purpose Health Care FSA**	$		$2,550 per year
3	**Dependent Day Care FSA**	$		$5,000 per year; $2,500 if married filing single
4	**Transit Reimbursement Account**	$		$1,560 per year/$130 per month
5	**Parking Reimbursement Account**	$		$3,000 per year/$255 per month

TASC CARD

You will receive one TASC Card for your ERA. You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

To request an additional TASC Card for your spouse or dependent, print his/her name below:

Spouse or Dependent Name (Last, First, MI): _____

AUTHORIZATION:

I elect to participate and agree to be bound by the terms of the Plan. I understand that:

- Employee Reimbursement Accounts (ERA) program is an optional benefit established for eligible state employees. The ERA program is also referred to as Flexible Spending Accounts or FSAs. The ERA program has five pretax benefit account options; Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, Dependent Day Care Flexible Spending Account, Transit Account, and Parking Account. The ERA Program is authorized under Internal Revenue Code Sections §125, §105, §129, and §132 and Wisconsin Statutes §40.85-§40.875.
- A new enrollment must be completed each plan year. If I do not complete enrollment during Open Enrollment, I forfeit the opportunity to participate in the Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Dependent Day Care Flexible Spending Account benefit options.
- The contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes.
- According to Wisconsin Statutes §40.87, participation in an Employee Reimbursement Account will not reduce my wages for calculating state retirement benefits. Also, my contributions in an Employee Reimbursement Account will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- My share of eligible group insurance premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible group insurance premium(s) deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefits office.
- Salary contributed into one account cannot be transferred and used for expenses in any other account.
- Participating in an Employee Reimbursement Account is completely voluntary, and that payments from my Employee Reimbursement Account are independently reviewed for compliance with IRS regulations.
- The IRS requires me to reimburse the Plan for any improper, erroneous, or excess reimbursement amount that I do no resolve within the timeframe provided by the Plan. In accordance with Wisconsin Statute §40.08(4), by enrolling in an Employee Reimbursement Account I specifically authorize the Plan Administrator, Department of Employee Trust Funds and/or my employer to withhold from my wages on a post-tax basis such amounts as are necessary to replenish my Employee Reimbursement Account(s) for any improper erroneous or excess reimbursement.
- If my employment terminates, only expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, and Dependent Day Care Flexible Spending Account elections can only be changed or revoked during the plan year if I have a qualified life change event as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the qualified life change event, and is subject to final approval by my employer. I cannot lower my election to an amount that is less than what I have already been reimbursed from my account. Whether I increase or decrease my election, my new election will be spread out evenly over my remaining pay periods.
- Parking Account and Transit Account elections can be changed or revoked prior to the first day of the next monthly coverage period. Elections can only be changed for future months. Upon termination or cessation or eligibility, my elections will be immediately revoked.
- If I am enrolled in a Health Care Flexible Spending Accounts or a Limited Purpose Flexible Spending Accounts, my eligible expenses must qualify as a medical deduction under Internal Revenue Service Publications.
- If I am enrolled in a Dependent Day Care Flexible Spending Account, my eligible expenses must qualify as Dependent Care deduction under Internal Revenue Service Publication 503. The expenses are for a qualified dependent (child under 13, spouse, or adult dependent unable to care for self), for care by a qualified dependent care provider, such as a day care center or individual, including non-dependent family member over 19, caring for my dependent(s) inside or outside the home.
- The maximum exclusion under a Dependent Day Care Flexible Spending Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- If I am enrolled in a Parking Account or Transit Account, my eligible expenses must qualify as a commuter benefit deduction under Internal Revenue Service Publication 5137.
- Any amounts remaining in excess of $500 in a Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account and any unused Dependent Day Care Flexible Spending Account at the close of the plan year will be forfeited in accordance with current Plan provisions and tax laws.

I certify that:

- I agree to have my compensation reduced by the contribution amount(s) I elected.
- That the information I have provided is complete and accurate to the best of my knowledge.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- That all dependents listed meet the eligibility requirements of the program.
- I shall not claim a federal income tax deduction or credit for any expenses that were reimbursed through my Employee Reimbursement Account(s).
- That my use of the Card will comply with the terms and conditions of the cardholder agreement received with the card.
- That all expenses charged on the Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed and are not reimbursable through any other means, including my or my dependent's insurance Plans.
- I will keep all receipts and other documentation related to expenses charged on the Card. Upon request, within forty-five (45) days, I will fax, mail, or upload the required documentation of expenses to the Third Party Administrator.
- I understand additional Cards issued to my spouse or dependent(s) will provide the named individual with access to my Employee Reimbursement Account(s). I accept all responsibility for Card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Card in violation of this enrollment agreement or the Cardholder agreement may result in the invalidation and forfeiture of the Card.
- If the Third Party Administrator determines that an expense I charged on the Card was not a qualified expense under the Plan or according to IRS rules, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to timely reimburse the Plan, I understand that amounts may be withheld from my wages or from an otherwise valid expense under this Plan in order to reimburse the unqualified expense.

Signature _____ **Date** _____

Enrollment Form Instructions

Instructions for entering elections under each applicable account type:

1. **Health Care FSA Election:** This amount you expect to pay out-of-pocket toward eligible medical expenses throughout the Plan Year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental expenses, orthodontic expenses, eye care, and other eligible healthcare expenses. Per IRS regulations, a Participant may elect a maximum of $2,550 per Plan Year (indexed annually for inflation). Your annual election will be split into equal amounts to be deducted pre-tax from every payroll throughout the Plan Year. Your total annual election amount is available for reimbursement on the first day of the Plan Year as eligible expenses are incurred.
2. **Limited Purpose Health Care Election:** If also enrolled in a Health Savings Account (HSA), you may participate in a Limited Purpose Health Care FSA plan that allows reimbursement for dental, vision, and post-deductible expenses only.
3. **Dependent Day Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the Plan Year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single. Plan funds are available as they are contributed.
4. **Transit Reimbursement Account Election:** Amount incurred to travel to and from work on mass transit facilities, or commuter highway vehicles. Examples of eligible expenses are vouchers, fare cards, or tokens for a bus, train, ferry, subway, or vanpool. Monthly limits apply.
5. **Parking Reimbursement Account Election:** Amount incurred for parking expenses at or near your place of employment or at a location from which you commute to work (e.g. ramp or park 'n ride). Monthly limits apply.

Frequently Asked Questions

1. What does an ERA offer? An Employee Reimbursement Account (ERA) offers you a choice to pay for certain qualified benefits on a pretax basis. Paying for certain benefits with pretax dollars reduces the amount you pay in taxes and increases your take-home pay. Every dollar paid on a pretax basis results in a savings to you.

2. Any cost or fee to me? No.

3. Must I participate in my employer's health insurance? The ERA is not tied to any insurance plan or company. You may participate in an ERA regardless of your particular insurance provider.

4. What are qualified medical expenses? These expenses include dental care, prescriptions, eyeglasses, and out-of-pocket medical expenses not covered by insurance. However, vitamins and other dietary supplements taken for general health purposes are not eligible. Purchases of over-the-counter (OTC) medicines and drugs (with the exception of insulin) are only reimbursable if accompanied by a prescription or Prescription Order Form from your medical practitioner. Participants in the Limited FSA can expense dental, vision, and post-deductible expenses. Below are some ***examples*** of eligible OTC health related expenses:

Examples of OTC items that require a prescription or Prescription Order Form: Acid Controllers, Allergy and Sinus, Antibiotic Products, Cough, Cold and Flu, Digestive Aids, Pain Relief, Respiratory Treatments, Sedatives, and Stomach Remedies.

Examples of OTC items that are eligible and need no physician authorization: Bandages, Blood Pressure Kits, Contact Lenses, Contact Lens Solution, Diabetes Testing Supplies, Durable Medical Equipment, Hearing Aid Batteries, Heating Pads, Insulin, Nebulizers, Thermometers, and Walkers and Wheelchairs.

5. How does the Dependent Day Care FSA compare with the tax credit available on the individual Form 1040? The circumstances that determine which option offers greater savings vary from family to family, as such, the decision to choose the tax credit or the dependent care deduction may be made on a case by case basis only. Participation in a Dependent Day Care FSA results in an immediate savings on Federal, State, and Social Security tax, whereas the Federal credit will affect Federal Income Tax only and will be taken at year-end.

6. How does a Cafeteria Plan affect Social Security benefits? Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower health care costs available with an ERA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.

7. Under what circumstances can the annual election be changed? The elections may be changed only if there is a change in family or employment status. See the Change of Elections Form for more detail.

8. Carryover for Health Care FSA and Limited Purpose Health Care FSA? Your employer offers the Carryover Provision which allows up to $500 of your account balance to automatically carry over into the next plan year once the run-out period has ended. Any remaining funds over $500 at the end of the plan year run-out period will be forfeited to your employer.

9. Who determines the rules and regulations of an ERA? Employee Reimbursement Accounts (ERAs) are regulated by the IRS. Our documentation guidelines are intended as a means to ensure eligibility of your requests for reimbursement. It is the Participant's responsibility to comply with these guidelines and to avoid duplication of requests or submission of ineligible charges. Failure to adhere to the above requirements could lead to payment delays or denial of expenses. In the event of an error or omission in the course of administering the Plan on behalf of the employer and participating employees, TASC will notify and remedy the error or omission. The employer and employees agree to TASC's procedures for making any corrections, including but not limited to payroll reduction. An error by the employer or TASC does not constitute an assumption of liability for the amount of the error.

NON-DISCRIMINATION POLICY

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) & (d)(1)

Total Administrative Services Corporation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TASC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TASC provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. TASC provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact TASC's Civil Rights Coordinator. If you believe that TASC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 2302 International Way, Madison, WI 53704; Phone: 1-608-316-2408; Fax: 1-877-231-1287; Email: CivilRightsCoordinator@tasconline.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, TASC's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-316-2408.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-533-5020 (TTY:1-800-947-3529).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

ملحوظة: إذا كنت تتحدث اللغة العربية فإن الخدمات المساعدة اللغوية متاحة لك مجانًا. اتصل برقم الهاتف الصم والبكم الخاص بك: 1-877-533-5020 (رقم

بـ رقم الهاتف: 1-800-947-3529)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529).번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 1-800-947-3529).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 1-800-947-3529).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529