

Save on Healthcare Costs with a Flexible Spending Account (FSA)

Medical Mutual FSA Enrollment Form





By selecting an FSA, you're making a smart decision to set aside pre-tax dollars to pay for eligible healthcare expenses. If you think you'll have medical expenses that won't be reimbursed by another plan, FSAs are a great way to save money while covering those costs.

Completing your enrollment is easy

Fill out your personal information and select the FSA(s) that are right for you. Talk with your employer to find out any contribution limits and which plans are available for your company. Please return your completed enrollment form to your employer.

For more information about FSAs, including videos and savings estimators, please visit MedMutual.com/myspendingaccounts.

Instructions

PLEASE PRINT CLEARLY. All information on both pages is required or your enrollment cannot be processed.

General Information

Employer

| | | | |
|-----------------------------|-------------------------|------------------------|-----|
| Employee Name (First, Last) | | Social Security Number | |
| Date of Birth (MM-DD-YYYY) | Date Hired (MM-DD-YYYY) | | |
| Street (Home Address) | | Apt. | |
| City | | State | ZIP |
| Home Phone | Email | | |

IMPORTANT

Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that the Medical Mutual debit card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the Medical Mutual debit card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with the Medical Mutual debit card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee signature _____ Date _____

Please return fully completed enrollment form to your employer.

This section to be completed by employer only.Does this employee have Medical Mutual insurance? Yes No

Please note: All employees with Medical Mutual insurance must actively be enrolled for FSA enrollment to be processed.

Plan year start (MM/DD/YY) ___/___/___ and end ___/___/___ . First payroll start date ___/___/___ . Number of Pays ___ Dept. _____

Employee Information (Required)**Employee Name (First, Last)****Social Security Number****Option 1A— Medical Mutual Flexible Spending Account (FSA)***

The FSA reduces your taxable income by setting aside pre-tax dollars to pay for eligible healthcare expenses.

 YES I elect to contribute **A** (before taxes) for the PLAN YEAR,* which is **B** per pay period, to fund my account that pays qualified out-of-pocket, healthcare expenses that are not covered by my employer's health plan or any other health plan.**A \$** _____ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.**B \$** _____**Option 1B— Medical Mutual Limited-Purpose Flexible Spending Account (LPF)***

The LPF is available only if you elect to enroll in a health savings account (HSA). The LPF is in addition to your HSA and is limited to paying only qualified dental and/or vision expenses that are not covered by your employer's health plan or any other health plan.

 YES I elect to contribute **A** (before taxes) for the PLAN YEAR,* which is **B** per pay period, to fund my account that pays qualified out-of-pocket, healthcare expenses not covered by my employer's health plan or any other health plan.**A \$** _____ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.**B \$** _____**Option 2— Medical Mutual Dependent Care/Elder Care Account (DCA)***

The DCA pays for day care expenses for a dependent child, adult or elder, so you may work. Eligible services include: nursery school, nanny, and before- or after-school care/day camp through age 12; day care for a disabled adult or child; and elder day care for parent or dependent.

 YES I elect to contribute **A** (before taxes) for the PLAN YEAR, which is **B** per pay period, to fund my account that pays qualified dependent day care or elder care expenses.**A \$** _____ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.**B \$** _____**Option 3— Agreement to Save Taxes on Insurance Premiums**

This option allows you to pay for your portion of your employer-sponsored insurance premiums on a pre-tax basis. Eligible expenses include health, dental and vision. Other insurance premiums may qualify. Please see your employer for more information.

 YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change. **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

*Account contributions are subject to IRS regulations and are subject to IRS limits. Based on IRS limits, your employer will determine contribution limit for your account. Please review your Summary Plan Description for contribution levels. You may contribute up to this amount for the plan year. This annual election amount will be deducted evenly out of each pay check on a pre-tax basis and deposited into your account.

Medical Mutual

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