RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS PLAN ENROLLMENT — PLAN YEAR 2024

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

Complete this form only if you wish to participate in the Medical, Limited Purpose or Dependent Care Reimbursement Account

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

HOME ADDRESS	CITY	STATE	ZIP CODE

DEPARTMENT NAME	DEPT ID / BUDGET CODE	DATE HIRED	EMPLOYEE ID (IF KNOWN)

WORK PHONE	PAYROLL FREQUENCY (PAYCHECKS PER YEAR)	ENROLLMENT STATUS
	❑ 12 ❑ 24 ❑ Other _____	❑ New Hire

REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your HR office for additional information or you may call Benefits Administration at 615.741.3590 or 800.253.9981.

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

In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the plan year.

MEDICAL EXPENSE ACCOUNT

Maximum allowable annual contribution is $3050

Box #1 Reduction per regular paycheck		
Box #2 Number of regular paychecks expected	X	
Box #3 Total plan year dollar amount	=	$0.00

LIMITED PURPOSE ACCOUNT

Maximum allowable annual contribution is $3050

Box #1 Reduction per regular paycheck		
Box #2 Number of regular paychecks expected	X	
Box #3 Total plan year dollar amount	=	$0.00

DEPENDENT CARE ACCOUNT

Tax Filing Status (please check one)

❑ Married, filing separately (maximum $2,500)
❑ Married, filing jointly (maximum $5,000)
❑ Head of household (maximum $5,000)

Box #1 Reduction per regular paycheck		
Box #2 Number of regular paychecks expected	X	
Box #3 Total plan year dollar amount	=	$0.00

See page 2 to complete the authorization and sign this form.

AUTHORIZATION

- 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 an approved family status change.
- 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 $610 remaining in either the Medical Expense Account or Limited Purpose Account at the end of the year will be forfeited. Funds of $610 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 either my participation in or 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.
- FSA and L-FSA debit card holders are required to provide proof that expenses paid for with the debit card are covered expenses permitted by the FSA program. This is called "substantiation." The State's authorized contractor may send requests for substantiation to plan members. The State cannot support the FSA program if employees fail to substantiate purchases on that card. Therefore, FSA and L-FSA debit card holders must consent to the State making deductions from their wages to repay expenses that cardholders fail to substantiate. Signature of this form is voluntary and no employee will be subject to employment based sanctions or termination from the FSA program for failure to sign. However, if a member refuses to sign it, the member will not be allowed to enroll in the FSA or L-FSA. All members who enroll in the FSA or L-FSA will receive a debit card but are not required to use it; participants may pay for qualified expenses out of pocket and file a claim with the State's authorized contractor for reimbursement.
- **I hereby agree that the State may deduct from my pay the amount of expenses that remain unsubstantiated thirty (30) days after the plan runout period and that authorization of payroll deduction is a condition for participating in a FSA or L-FSA. The State will provide notice of such deductions 14 days before the date of payment of your wages as required by TCA 50-2-110.**

EMPLOYEE SIGNATURE	DATE

Return this application to your human resource office after making a copy for your records.
For questions regarding enrollment or a family status change, 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.