Flexible spending accounts Enrollment or change form

BENEFITHelp Solutions

** This information is mandatory. Enrollment may be delayed if fields with an asterisk are not filled out.*

Section 1 Application reason

PLEASE PRINT CLEARLY

* Reason for application	* Change reason	* Effective date

Section 2 Account holder information

* First name	M.I.	* Last name	* Date of birth	* Membership identification or SSN

* Mailing address	* City	* State	* ZIP

* Email address	* Contact number

* Employer	* Group identification number (if known)
Norris & Stevens, Inc.	9210

Section 3 Benefit election (check all that apply)

☐ Waive participation	You will not be eligible to participate in the healthcare or dependent care account until the next open enrollment period unless an applicable change of status occurs. Please notify your employer of any change in status within 30 days of the applicable change.			
☐ Enroll me in the healthcare flexible spending account (FSA)	Date of first pay period deduction	Number of remaining pay periods	Pay period amount	* Annual election (up to $2,650)
☐ Enroll me in the dependent care assistance program (DCAP) If married and filing seperately, DCAP election should not exceed $2,500	Date of first pay period deduction	Number of remaining pay periods	Pay period amount	* Annual election (up to $5,000)

Pay period amount x Pay periods in the plan year = Annual election

Section 4 Reimbursement (for explanations, please review page 2)

Benefits card	☐ I would like a Benefits MasterCard	☐ I already have a Benefits MasterCard	☐ I would like a Benefits MasterCard card for my dependent over age 18	
	Dependent's first name	Dependent's last name	Dependent's identification number or SSN	Dependent's date of birth

Direct deposit	☐ Enroll me in direct deposit	☐ Checking ☐ Savings	Bank name
	Rounting number	Account number	

Section 5 Authorization

I have read and agree to the terms and conditions on pages 1 and 2 and authorize my employer to reduce my salary on a per-pay-period basis.	
* Employee signature X	* Signature date

Please return to your human resources or benefits department upon completion.

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Flexible spending account reimbursement form

BENEFIThelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of this form. If this form is incomplete or requires additional information, your reimbursement may be delayed. Please do not use a fax cover sheet.

☐ Check box if this claim is to offset a previously submitted ineligible expense.

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Mailing address		* City	* State / * ZIP
* Contact number	* Email address		☐ New address
* Employer			* Group identification (if known) #

Section 2 Reimbursement request

1	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
2	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
3	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
If you need more space, please use page two. Each page will contain its own total.			* Total on this form	

Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. For a list of common eligible and ineligible expenses and additional information on substantiation please visit benefithelpsolutions.com/pdfs/fsa_expenses.pdf. An explanation of benefits provided by your insurance company **is** acceptable substantiation. You may need to submit a letter of medical necessity at benefithelpsolutions.com/pdfs/med_necessity_ltr.pdf to establish the medical necessity of your medical expenses. For orthodontia expenses, BenefitHelp Solutions must have a copy of your orthodontia contract on file.

Section 3 Authorization (please read and sign below)

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for my own personal expenses.
- These services have already been provided or paid for.
- I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation or if there is reason to believe the expense is not qualified as defined under the conditions in my Summary Plan Document or regulatory guidance.

* Employee signature	* Signature date
X	

** Reimbursement may be delayed if fields with an asterisk are not filled out.*

Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Additional reimbursement requests

Account holder information

*First name	M.I.	*Last name	*Membership identification
* Employer			*Group identification (if known)

Reimbursement request

4	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
5	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
6	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
7	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
8	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
9	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
10	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
11	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
12	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
Each page will contain its own total.			* Total on this form	

Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. For a list of common eligible and ineligible expenses and additional information on substantiation please visit benefithelpsolutions.com/pdfs/fsa_expenses.pdf. An explanation of benefits provided by your insurance company **is** acceptable substantiation. You may need to submit a letter of medical necessity at benefithelpsolutions.com/pdfs/med_necessity_ltr.pdf to establish the medical necessity of your medical expenses. For orthodontia expenses, BenefitHelp Solutions must have a copy of your orthodontia contract on file.

** Reimbursement may be delayed if fields with an asterisk are not filled out.*