THE CHOICE CARE CARD™

In order to receive your **Choice Care Card** you need to complete the enrollment form on the reverse side of this pamphlet and return it to your employer.

You card will be mailed to your home shortly after our receipt of this enrollment form from your employer. Please look for it in the mail as it will arrive in a plain white envelope. You will also receive a **Welcome Kit** from your employer which will explain in detail how to use the card.

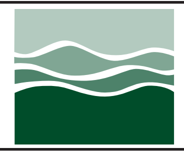
THE CHOICE CARE CARD™

76 McNeil Road, 2nd Floor
Waterbury Center, VT 05677
www.choicecarecard.com
Phone: 888-278-2555
Fax: 802-223-7887

THE CHOICE CARE CARD™

Your employer is implementing a Health Reimbursement Arrangement (HRA) for you. The HRA is a fund of money available to you to use in conjunction with your health insurance plan. The HRA can be used to pay for certain out of pocket expenses that you may incur such as deductible or co-insurance expenses. Specific coverage details of your HRA are outlined on the enclosed Funding Summary.

You will be provided a Choice Care debit card in order to access the funds in your HRA. The Choice Care Card is easy to use. When you are receiving services or have a bill from your provider for an eligible expense you simply use The Choice Care Card to pay the bill!



EMPLOYER FUNDS ONLY (HRA)

ENROLLMENT FORM/CHANGE OF STATUS

COMPANY NAME: ______________________________

Effective Date: ______________________________

Please Check One

- ☐ **This is a regular annual election**
- ☐ **I am a new employee**
- ☐ **There has been a change in my family status**
- ☐ **This is a termination**

Change is due to:

- ☐ Marriage
- ☐ Spouse became employed
- ☐ Change in work hours
- ☐ Divorce/separation
- ☐ Death of spouse/child
- ☐ Spouse ceases to be employed
- ☐ Unpaid Leave of absence
- ☐ Birth or Adoption of child
- ☐ Other (Please explain:) ______________________________

Date change occurred on: ______________________________

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Legally Separated
- ☐ Divorced
- ☐ Widowed

I participate in the health plan as a:

- ☐ Single
- ☐ Employee & Spouse
- ☐ Employee & Child
- ☐ Family

Employment Date:

Birth Date:

Social Security Number

Last Name (please print)	First Name	MI	Gender: ☐ Male ☐ Female
Mailing address (Street or PO Box)	City	State	Zip
Phone Number	Email Address - Necessary to receive email communication on your account.		

List eligible dependents to be covered in order of age (including spouse)

Last Name (if different)	First	MI	Relationship	DOB	Sex (M/F)	Full Time Student?	S.S. #

AUTHORIZATION OR WAIVER OF PARTICIPATION

I request to participate in the benefits indicated above. I understand that my elections indicated above are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan. I further certify that any dependents for whom I will be claiming dependent care or health care expenses will be claimed by me as dependents on my federal and state tax returns. If I have waived participation, I understand that I may not join the Plan until the start of the next plan year.

Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses that are not covered by any other plan. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account. I understand that these expenses cannot be claimed on my income tax return.
By signing this form I hereby authorize my employer to deduct any ineligible expenses paid for with *The Choice Care Card*™ from my paycheck. I understand that any unauthorized use may result in the loss of my *The Choice Care Card*™.

☐ I elect to participate in *The Choice Care Card*™ HRA plan ☐ I do not elect to participate in *The Choice Care Card*™ HRA plan

Direct Deposit (ACH): When filing claims manually, I hereby authorize **The Choice Care Card** to Credit the account indicated below:

Account Number: ______________________ Transit Routing Number (9 digits): ______________________

Type of Account: ______________________ ☐ Checking

By signing below I hereby authorize the release of claim information to my employer and *The Choice Care Card*™ administrator.

Employee Signature: ______________________________ Date: ______________________

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(revised 5/30/2007)

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Making Your FSA and DCAP Election

In order to complete the enrollment form you will need to determine how much money to put aside out of your paycheck on a per pay period basis. The list of eligible expenses included with this pamphlet should help you with that calculation.

You can also go to **www.choicecarecard.com** and click on the FSA & You icon YOUR GUIDE TO Flexible Spending Account for more help in making your FSA or DCAP election.

Plan your election carefully. Once an election is made it can not be changed except under specific circumstances such as a change in family status.

The money you have elected will come out of your paycheck on a **pre-tax** basis and be posted to your Choice Care Card account on the same schedule.

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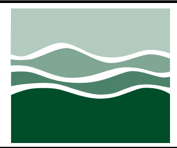
Welcome to

THE CHOICE CARE CARD™

Your employer is implementing a Flexible Spending Account (FSA) and Dependent Care Assistance Plan (DCAP) for your benefit. An FSA and or DCAP will save you money by enabling you to set aside money out of your paycheck on a **pre-tax** basis to pay for out of pocket health, dental, vision, prescription and over-the-counter medication as well as day care expenses. The tax savings to you can be significant. A partial list of eligible expenses is included with this enrollment brochure. Funding limits are outlined on the Funding Summary Sheet.

You will be provided a Choice Care debit card in order to access the funds in your FSA or DCAP. The Choice Care Card is easy to use. When you are receiving service or have a bill from your provider for an eligible expense you simply use The Choice Care Card to pay the bill!



EMPLOYEE FUNDS ONLY (FSA)

ENROLLMENT FORM/CHANGE OF STATUS

COMPANY NAME: ______________________________

Effective Date: ______________________ **Date of First Payroll Deduction:** ______________________

Please Check One
- ☐ This is a regular annual election
- ☐ I am a new employee
- ☐ There has been a change in my family status
- ☐ This is a termination

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Legally Separated
- ☐ Divorced
- ☐ Widowed

Employment Date:

Birth Date:

Change is due to:
- ☐ Marriage
- ☐ Death of spouse/child
- ☐ Spouse becomes employed
- ☐ Spouse ceases to be employed
- ☐ Change in work hours
- ☐ Unpaid Leave of absence
- ☐ Divorce/separation
- ☐ Birth or Adoption of child
- ☐ Other (Please explain:) ______________________

Date change occurred on: ______________________

Social Security Number

I participate in the health plan as a:
- ☐ Single
- ☐ Employee & Spouse
- ☐ Employee & Child
- ☐ Family

Last Name (please print)	First Name	MI	Gender: ☐ Male ☐ Female
Mailing address (Street or PO Box)	City	State	Zip
Phone Number	Email Address - Necessary to receive email communication on your account.		

List eligible dependents to be covered in order of age (including spouse)

Last Name (if different)	First	MI	Relationship	DOB	Sex (M/F)	Full Time Student?	S.S. #

PLAN YEAR ELECTIONS.

I authorize my employer to deduct a pre-tax contribution from my compensation for the following benefits:

☐ Flexible Spending Account (reimbursement for health care expenses not paid from any other source.)

Amount per pay period: $ *Annual Election:* $

☐ Dependent Care Reimbursement Account (day care expenses for eligible dependents)

Amount per pay period: $

AUTHORIZATION OR WAIVER OF PARTICIPATION

I request to participate in the benefits indicated above. I understand that my elections indicated above are binding upon me for the entire Plan year and cannot be revoked, modified or amended unless due to very limited changes in family status as described within the Plan. I further certify that any dependents for whom I will be claiming dependent care or health care expenses will be claimed by me as dependents on my federal and state tax returns. If I have waived participation, I understand that I may not join the Plan until the start of the next plan year.

Under penalty of perjury I agree to use the debit card solely for the purchase of eligible expenses that are not covered by any other plan. I understand that I am responsible for providing proof to support the reimbursed expense, and any reimbursed expense later discovered to be ineligible must be repaid to the account. I understand that these expenses cannot be claimed on my income tax return.
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☐ **I elect** to participate in *The Choice Care Card*™ FSA plan ☐ I do not elect to participate in *The Choice Care Card*™ FSA plan

DIRECT DEPOSIT (ACH): When filing claims manually, I hereby authorize **The Choice Care Card** to credit the account indicated below:
Account Number: ______________________ Transit Routing Number (9 digits): ______________________
Type of Account: ______________________ ☐ Checking

By signing below I hereby authorize the release of claim information to my employer and *The Choice Care Card*™.

Employee Signature: ______________________ Date: ______________________