The BESTflex℠ Plan
Employee Benefits Corporation

Enrollment Form with Health Savings Accounts

Plan Participants
Phone support: **www.ebcflex.com**
Fax to: **(800) 346-2126 | (608) 831-8445**

Submit completed form to your employer.

Employers
Secure upload: **Submit completed forms via: www.ebcflex.com**
Fax to: **(608) 831-4790**
Mail to: **Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347**

General Information

Stoughton Hospital Association
Organization Name

Division

Participant Information (Please print)

Last Name | Suffix | First Name | MI

Gender: ○ M ○ F

Date of Birth (mm-dd-yyyy)

Date of Hire (mm-dd-yyyy)

Participant Social Security or Identification Number

Mailing Address | Apt. No. | City | State | Zip Code

Home Phone 123-456-7890

E-mail Address (we do not share your e-mail address)

Plan Dates (refer to "My Company Plan" Eligibility section)

Effective Start Date (mm-dd-yyyy): 01-01-2023

Number of Pay Periods: 26

Plan Benefits: I elect to have Elections below deducted from my pay tax-free and placed into the following accounts

	Employee Election per Pay Period	**Employee** Election Plan Year Total	**Employer** Contributions (if any) Plan Year Total
Standard Health Care FSA Reimburses all eligible medical expenses; not for use with HSA	$	$	$ 0.00
Limited Health Care FSA With HSA only; reimburses dental and vision expenses only	$	$	$ 0.00
Dependent Care FSA Reimburses eligible child or elder care expenses (e.g., daycare)	$	$	$ 0.00
Employee Paid Administrative Fees (if any)	$ 0.00	$ 0.00	$ 0.00
HSA Contribution Enter the per-paycheck payroll deduction	$	$	$
Total Election Amount	$	$	$

Direct Deposit (optional; if you have not done so, complete banking information below to participate – authorization is in effect from plan year to the next)

Financial Institution | City | State | Zip Code

○ Checking ○ Savings

Account Number

Routing Number (exactly 9-digits)

Authorization

◉ I enroll in the BESTflex Plan ○ I do not wish to enroll in the BESTflex Plan

I agree this election cannot be revoked or changed during the plan year, unless a qualifying event occurs to justify the revocation or change as authorized by the IRC and Regulations. I understand my Social Security benefits may be affected by my participation in this Plan and that any money I allocate to these accounts and do not spend by the end of the plan year (or grace period, if elected by the plan sponsor) cannot be returned to me (HSA contributions are exempt from this rule). Your annual election will be rounded down if it is not evenly divisible by the number of paychecks. If a debit card has been provided to me, I certify I will only use the Card for payment of eligible expenses under the Plan and any expense paid with the Card will not be reimbursed nor will I seek reimbursement under another Plan. I agree to provide substantiation that any expense is eligible for reimbursement under the Plan, and to reimburse the Plan in cases where I have been reimbursed in error for an expense ineligible under the Plan. I understand that if I fail to reimburse the Plan for an ineligible expense, my employer may withhold the amount I owe the plan from my wages when permitted by applicable state law. By signing this Enrollment Form, I acknowledge that Employee Benefits Corporation will use my (and my dependants as applicable) "protected health information" for purposes of providing benefit administration services to the Plan. Any information disclosed pursuant to this Enrollment Form will not be subject to redisclosure by the recipient, except for purposes of the Plan. I understand that my enrollment can be denied if I do not sign this form.

If Direct Deposit is elected for reimbursement, I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.

Signature

Date (mm-dd-yyyy)

