KING'S COLLEGE
TRANSFORMATION. COMMUNITY. *HOLY CROSS.*

2016 OPEN ENROLLMENT

KING'S COLLEGE

Creative Benefits, Inc.
strategies to insure your success

2016 EMPLOYEE BENEFITS

Employee Benefits

Employee Benefits Program
Plan Year: July 1, 2016 - June 30, 2017

What's New for 2016?

It is the goal of King's College to offer a strong benefits program while striving to maintain an equitable cost versus benefits balance. Our commitment to a well-rounded benefits program goes beyond medical and prescription benefits to include dental and vision coverage as well as life insurance and long term disability.

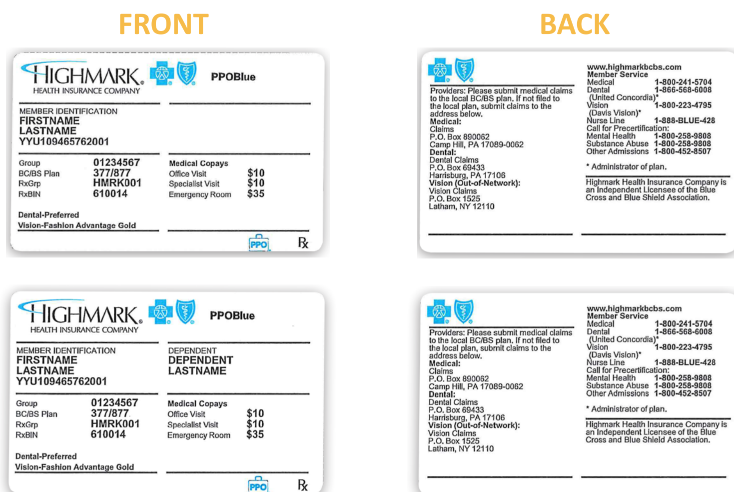
As a Full-Time eligible employee, the following benefits are available to you and outlined on the following pages:

- **Pages 4-6: Medical & Prescription -** Highmark Blue Cross Blue Shield
- **Page 7: Dental -** Delta Dental *NEW*
- **Page 8: Vision -** Vision Benefits of America
- **Page 9-10: Flexible Spending Accounts -** Ameriflex
- **Pages 13-14: Life Insurance/AD&D and Long Term Disability -** Guardian

Introducing the New Highmark Blue Cross and Blue Shield ID Cards

All employees and their dependents will be receiving new ID cards for use beginning July 1, 2016. New with Highmark, every dependent will be receiving an ID with the employee name and their name. To ensure claims are processed correctly be sure to show the new cards to your health care providers and pharmacists after July 1st.

Your ID cards will arrive with a Coordination of Benefits (COB) sticker affixed to the front. COB is needed when you or your dependent has dual medical insurance coverage. Please call the number on the sticker to report your other coverage. This will eliminate claims payment delay.



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HOW TO ENROLL

PLEASE NOTE: *You must take action in order to secure coverage with all benefit lines on/and after July 1, 2016. You are required to enter the Benefit Enrollment Portal in Web Advisor to re-elect your benefit options or to make any modifications to your current benefit elections, i.e.* ***add/ remove a dependent, change plan options or enroll for the first time.***

Once you have made your benefit elections, they will remain in effect until the next Open Enrollment unless you experience a "change in status" e.g. marriage, divorce, birth, adoption, or a child reaching the plan age limit (26).

You have 30 days from the date of a qualifying change in status to notify HR department if you wish to change your benefits. If you do not make the notification within that timeframe, your changes will not be effective until the next Open Enrollment period.

Employee Service Representatives

Benefits can be confusing. Insurance companies are hard to reach.

We understand. Trust the ESR team at Creative Benefits, Inc. to help. The team members' combined benefits experience of over 35 years will guide you through the confusion.

Your ESR will assist you with...

- questions or concerns about your benefits;
- a claim that was denied by your insurance;
- a doctor bill for which you are not responsible;
- ordering a new ID card;
- enrolling in benefits for the first time or making changes;
- finding providers that are in your network.

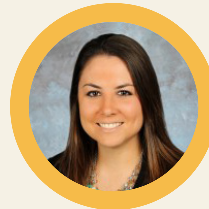
Your ESR Team

Charmaine Harrison-Tummings - ESR Team Leader

The Rest of the Team

Marie D'Antonio

Marlene Loose



Katelyn Martin

Christa Wisneski

Hours of Operation: 7:30 a.m. to 6 p.m. EST | Phone: 844-231-8414 | Email: ESR@creativebenefitsinc.com

Medical Benefits

Highmark Blue Cross and Blue Shield

King's College will continue to offer the choice of three PPO plans. The Value Plan, the Core Plan, and the Premier Plan. The choice is yours, but there are advantages to choosing in-network providers such as lower copays and reduced out-of-pocket expenses.

To locate a participating doctor or facility, visit ***www.highmarkbcbs.com*** and for customer service call: **1-800-241-5704**.

	Value Plan **Custom PPO - $300 Ded**	**Core Plan** **PPO - $500 Ded**	**Premier Plan** **PPO - $150 Ded**
In-Network Coverage			
Primary Doctor Visit	$25 copay	$15 copay	$15 copay
Specialist Visit	$35 copay	$25 copay	$25 copay
Preventive Tests such as: ACA approved preventive services	100% (office visits may be subject to applicable copay)	100% (office visits may be subject to applicable copay)	100% (office visits may be subject to applicable copay)
Complex Radiology (i.e. MRI)	$75 copay per test	$75 copay per test	$75 copay per test
Physical, Speech and Occupational Therapy	20% after deductible	20% after deductible	10% after deductible
Chiropractic Care, Mental Health Outpatient, Durable Medical Equipment	20% after deductible	20% after deductible	10% after deductible
Routine Eye Exam	Not Covered	Not Covered	Not Covered
Retail/Urgent Care	$50 copay	$50 copay	$50 copay
Emergency Room (waived if admitted)	$100 copay no deductible	$100 copay no deductible	$100 copay no deductible
Deductible and Related Services			
In-Network Member Responsibility	**$300 Single** **$600 Family**	**$500 Single** **$1,000 Family**	**$150 Single** **$300 Family**
Co-Insurance	20%	20%	10%
Co-Insurance Maximum	$3,000 Single $6,000 Family	$3,000 Single $6,000 Family	$2,000 Single $4,000 Family
Out-of-Pocket Maximum (deductible & copays are included)	$6,600 Single $13,200 Family	$6,600 Single $13,200 Family	$6,600 Single $13,200 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital Care, Outpatient Surgery, Lab / Radiology Services	20% after deductible	20% after deductible	10% after deductible
	BlueCard Network	**Out-of-Network**	**Out-of-Network**
Deductible	$1,200 Single $2,400 Family	$2,000 Single $4,000 Family	$1,000 Single $2,000 Family
Co-Insurance	40%	30%	30%
Co-Insurance Maximum	$8,000 Single $16,000 Family	$8,000 Single $16,000 Family	$5,000 Single $10,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited

This is a brief summary only, refer to your plan document for complete details. If any discrepancies exist between the above and the plan document, the plan document will prevail.

Bi-Weekly Medical Benefit Payroll Deductions			
	Value Plan	**Core Plan**	**Premier Plan**
Single	$23.00	$49.00	$78.00
Employee + Child(ren)	$48.00	$106.00	$146.00
Employee + Spouse	$65.00	$121.00	$176.00
Family	$94.00	$178.00	$251.00

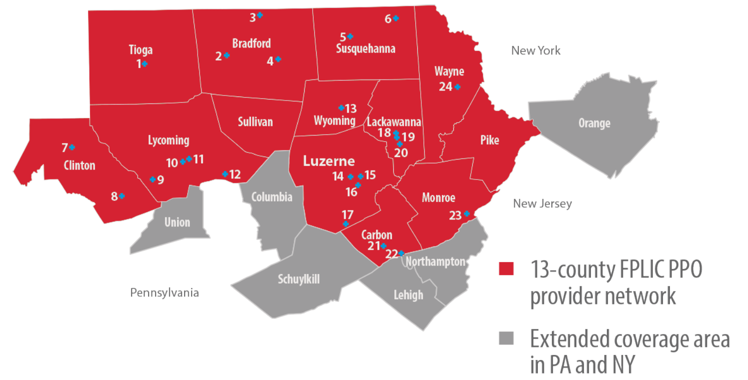
Networks

Custom PPO (Value Plan)

Network Providers

The Custom PPO provider network includes:

- All of First Priority Life®'s (FPLIC) PPO network providers and Blue Distinction® Centers for Transplants.



Out-of-Network Providers

- BlueCard® PPO national network providers and any other non-participating providers.
- Who Should Enroll? Those who live and seek care locally.

FPLIC PPO network hospitals

Counties	Tioga Bradford Susquehanna	Clinton Lycoming Sullivan	Luzerne Wyoming	Lackawanna	Carbon Monroe Pike Wayne
Hospitals	1. Soldiers + Sailors Memorial Hospital 2. Troy Community Hospital 3. Robert Packer Hospital 4. Memorial Hospital—Towanda 5. Endless Mountains Health System 6. Barnes Kasson County Hospital	7. Bucktail Medical Center 8. Lock Haven Hospital 9. Jersey Shore Hospital 10. Williamsport Hospital 11. Divine Providence Hospital 12. Muncy Valley Hospital	13. Tyler Memorial Hospital 14. Wilkes-Barre General Hospital 15. Geisinger Wyoming Valley Medical Center 16. Department of Veterans Affairs Medical Center 17. Lehigh Valley Hazleton, Hospital	18. Regional Hospital of Scranton 19. Moses Taylor Hospital 20. Geisinger Community Medical Center	21. Gnaden Huetten Memorial Hospital 22. Palmerton Hospital 23. Pocono Medical Center 24. Wayne Memorial Hospital

- AND, several hospitals and their participating doctors, located just beyond our 13-county service area:

PA					NY
Columbia County	**Lehigh County**	**Northampton County**	**Schuylkill County**	**Union County**	**Orange County**
• Berwick Hospital Center • Geisinger-Bloomsburg Hospital	• Lehigh Valley Hospital, Allentown • St. Luke's University Hospital, Allentown Campus	• St. Luke's University Hospital, Bethlehem Campus • St. Luke's University Hospital, Anderson Campus, Easton • Lehigh Valley Hospital-Muhlenberg, Bethlehem	• St. Luke's University Hospital, Miners Campus, Nesquehoning	• Evangelical Community Hospital, Lewisburg	• Bon Secours Community Hospital, Port Jervis This hospital is in network. Not all doctors affiliated with this hospital are in network.

Core and Premier Plans Network

In-Network: National BlueCard Network. Access to nationwide physicians and facilities.

Out-of-Network: Non-participating Blue Cross providers and facilities.

Who Should Enroll? Those that live outside the 13-county service area, including out of state residents or those who wish to have access to medical treatment outside of the 13 county area without additional out-of-pocket expenses.

Prescription Benefits

Express Scripts

Your prescription drug coverage is a formulary-based plan administered by Express Scripts in conjunction with your medical plan. A formulary plan is a defined list of drugs that are FDA approved and selected by the Pharmacy Benefit Manager (PBM) based on effectiveness and value. The medical plan in which you enroll determines your co-pays for prescription, please see below for applicable co-pays:

	Value Plan	Core Plan	Premier Plan
Retail Pharmacy (30-day Supply)			
Tier 0 - Select Generics	$0 copay	$0 copay	$0 copay
Tier 1 - Generic Formulary	$10 copay	$10 copay	$10 copay
Tier 2 - Brand Formulary	$35 copay	$20 copay	$20 copay
Tier 3 - Non-Formulary Brand	$55 copay	$35 copay	$35 copay
Coverage for Specialty Prescriptions on the Value Plan are 20% of the prescription cost to a maximum of $150.			
Mail Order Pharmacy (90-day Supply)			
Tier 0 - Select Generics	$0 copay	$0 copay	$0 copay
Tier 1 - Generic Formulary	$20 copay	$20 copay	$20 copay
Tier 2 - Brand Formulary	$70 copay	$40 copay	$40 copay
Tier 3 - Non-Formulary Brand	$165 copay	$105 copay	$105 copay

Prescription Plan Highlights:

Mandatory Generic: The prescription drug plan requires a member take a generic prescription when available. If the member chooses to use the brand name of the drug when there is a generic equivalent the member will be charged a copay plus the difference in the cost of the generic & brand name medication.

Mail Order: Mail order is available for maintenance drugs. Maintenance medications are those prescribed for an extended period of time to treat a chronic condition (e.g. high blood pressure). To participate in this program, you should ask your doctor to write two prescriptions for you—one for a 30 day supply to be filled immediately at the retail pharmacy and one for the 90 day supply (plus any refills) to be filled via the mail order program.

Prior Authorizations & Step Therapy:

Certain medications require prior authorization by your physician or the use of a therapeutic alternative prior to the use of the medication that requires prior authorization.

Members existing BCNEPA step therapy history and most prior authorization information will be transferred to their Highmark profile.

There may be additional drugs requiring prior authorization.

In general the Highmark Formulary has considerably less drugs that need step therapy.

You can check how your drugs are covered on
Highmark's formulary website at
highmarkbcbs.com.
Click on the
'Find a Doctor or Rx' tab
at the top of the page.

Formulary Name:
The Comprehensive Incentive Formulary

This is a brief summary only, refer to your plan document for complete details. If any discrepancies exist between the above and the plan document, the plan document will prevail.

Dental Benefits

Delta Dental

With Delta, you have three network levels to choose from: in-network PPO; in-network Premier; or out-of-network. The PPO network of dentists accept reduced fees for covered services (typically lower than the Premier network dentists), so you will usually pay the least when you visit a PPO network dentist. Premier network dentists also accept a discounted fee, but not quite as low as the PPO dentists, so you may have higher coinsurance share for services performed by a Premier dentist. For out-of-network services, you will be balance-billed for the difference between Delta Premier network's allowance and the provider's charge (in addition to the coinsurance).

Benefits may be subject to age or frequency limitations. If the charge for any dental treatment is expected to exceed $300, have your dentist submit a dental treatment plan for review before treatment begins.

Go to www.deltadentalins.com to find an in-network dentist; select "Find a Dentist," and choose either the PPO or Premier networks. For Customer Service, please call **800-932-0783**.

	PPO Network	Premier Network	Out-of-Network
Benefits Maximum	$1,500 Per Calendar Year Per Person		
Annual Deductible Waived for Diagnostic and Preventive	$50 Per Individual Per Plan Year $150 Per Family Per Plan Year		
Out-of-Network Reimbursement	Premier Network Contracted Fees (balance billing may occur)		
Exams, Bitewing X-Rays, Cleanings, Fluoride Treatments, Sealants	100%	100%	100%
Amalgam and Composite Restorations, Periodontics, Endodontic, Oral Surgery	100%	100%	100%
Crowns/ Inlays, Bridges, Dentures	60%	60%	60%
Orthodontic Benefits - Children Only	50%	50%	50%
Orthodontic Maximums	$1,500 Per Lifetime Per Child		

Bi-Weekly Dental Benefit Payroll Deductions	
	Plan Costs
Single	$10.51
Employee + 1	$19.05
Family	$27.86

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Vision Benefits

Vision Benefits of America

Your vision plan through VBA allows you to see any eyecare provider that's right for you. However, your out-of-pocket costs will be lower if you see a VBA participating doctor.

***** No ID card is necessary.*** Prior to your appointment, visit www.vbaplans.com and either print your benefit form or find a provider that uses the e-claim system. If you use a doctor that files an e-claim, simply make your appointment and tell the doctor that you are a VBA member and that you would like to use the e-claim system.

If you visit a doctor not in VBA's network, you will need to pay the full fee at the time of the service and then submit an itemized bill to VBA for reimbursement.

To find a VBA doctor, visit www.vbaplans.com. For Customer Service, call **800-432-4966**.

	In-Network	Out-of-Network
Examinations (every 12 months)		
Exams	100%	Up to $40 Reimbursement
Materials	$10 copay	N/A
Standard Lenses (every 12 months)		
Single Vision	100%	Up to $40 Reimbursement
Bifocal	100%	Up to $50 Reimbursement
Trifocal	100%	Up to $75 Reimbursement
Lenticular	100%	Up to $100 Reimbursement
Progressive	Controlled Cost*	Up to $75 Reimbursement
Contact Lenses, Evaluation & Fitting (in lieu of glasses, every 12 months)		
Elective	Up to $150 allowance	Up to $150 Reimbursement
Medically Necessary	UCR**	Up to $300 Reimbursement
Frames (every 12 months)		
At Provider's Location	$50 wholesale allowance (approximately $125–$150 retail)	Up to $50 Reimbursement

***** Progressive lenses typically retail from $150 to $400, depending on lens options. VBA's controlled costs generally range from $45 to $175.***

****** Usual, Customary and Reasonable as determined by VBA***

Bi-Weekly Vision Benefit Payroll Deductions	
	Plan Costs
Single	$1.57
Family	$4.38

This is a brief summary only, refer to your plan document for complete details. If any discrepancies exist between the above and the plan document, the plan document will prevail.

Life/AD&D Insurance/ Long Term Disability

Guardian

If you have questions about any of the following insurance plans, please contact Luzan Bent at Creative Benefits at 866-306-0200 or lbent@creativebenefitsinc.com.

Life/ Accidental Death & Dismemberment - Paid by King's College	
Eligible Class	All eligible employees – Administration and staff working 35+ hours and faculty working 15+ hours
Life Benefit	1.5 X Salary to $100,000
Accidental Death & Dismemberment	1.5 X Salary to $100,000
Reduction Schedule	To 67 percent at age 70; to 45 percent at age 75; tp 30 percent at age 80
Waiver of Premium	Included
Conversion/ Portability	Included
Accerelated Death Benefit	Included
Benefits Terminate	Upon retirement or termination

IMPUTED INCOME: Under Section 79 of the Internal Revenue Code, employer provided group term life coverage will generate additional taxable income to the employee if covered for more than $50,000.

Long Term Disability - Paid by King's College	
Eligible Class	All eligible employees – Administration and staff working 35+ hours and faculty working 15+ hours
LTD Benefit	60% to $4,000 monthly
Benefit Duration	Social Security Normal Retirement Age
Benefits Begin After	180 days
Pre-Existing Condition Limitation	3/12 - A pre-existing condition is defined as one where you sought treatment for months prior to being covered.

This is a brief summary only, refer to your plan document for complete details. If any discrepancies exist between the above and the plan document, the plan document will prevail.

Voluntary Life Insurance

Guardian

If you have questions about any of the following insurance plans, please contact Luzan Bent at Creative Benefits at 866-306-0200 or lbent@creativebenefitsinc.com.

Voluntary Life Benefit - Paid by Employee	
Life Benefit	**Employee:** $10,000 increments up to $300,000 (Guarantee Issue: $50,000) **Spouse:** $10,000 increments up to $300,000– not to exceed 100% of employee election. (Guarantee Issue: $10,000) **Child (14 days—26 if FT student):** $10,000 (Guarantee Issue: $10,000)
Reduction Schedule	To 67 percent at age 70; to 45 percent at age 75; to 30 percent at age 80
Portability/ Conversion Option	Termed coverage can be continued on an individual basis should you leave. (Termed rates also age banded)
Accelerated Death of Benefit	75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $300,000.
Waiver of Premium	If it is determined that you are totally disable, your life insurance benefit will continue without payment of premium, subject to certain conditions.

Employees can opt to purchase additional life insurance through payroll deductions. The rates are age-banded, therefore your rates will change only when you move from one age-band to another. Employees and dependents who are currently enrolled and who do not wish to make any changes will continue to be enrolled for the upcoming plan year.

Please note that employees have to elect coverage for themselves in order to be eligible to elect dependent coverage.

Please see the Human Resources Department or go to http://www.kings.edu/hr/benefits to obtain the necessary forms for enrollment in this voluntary benefit.

This is a brief summary only, refer to your plan document for complete details. If any discrepancies exist between the above and the plan document, the plan document will prevail.

Flexible Spending Accounts

AmeriFlex

Healthcare Spending Account

This account will reimburse you with pre-tax dollars for healthcare expenses not reimbursed under your medical plan. In general, expenses incurred to treat a medical condition or to alleviate pain are eligible for reimbursement. ***The annual contribution maximum for the medical spending account is $2,550 per calendar year***. The amount you elect for the calendar year is deducted on a pre-tax basis for this purpose (deductions are made in equal increments over the course of the year). There is a ***$300 minimum*** contribution that needs to be made per calendar year.

Some Examples of eligible expenses are:

- Office visit and prescription copays
- Dental expenses, including orthodontia payments (**AmeriFlex will require proof of charges for all dental expenses so please keep your receipts and EOB's**).
- Eye Exams and Materials, Laser Eye Surgery (**AmeriFlex will require proof of charges for all vision expenses so please keep your receipts and EOB's**).
- Certain Over the counter items i.e.: contact lens solutions, band aids
- *Over-the-counter (OTC) Medications will require a prescription prior to the purchase to be considered an eligible FSA expense.*

Dependent Care Spending Account

This account will reimburse you with pre-tax dollars for daycare expenses for your children and other qualifying dependents so that you and your spouse may go to work or school. Up to **$5,000** may be set aside on a pre-tax basis (or **$2,500** if you are married and file separate returns). Eligible Dependents include children under age 13 and children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return. ***There is a $300 minimum contribution that needs to be made per calendar year.***

Eligible Expenses include:

- Daycare, including nursery school or preschool; Before and after school programs
- Adult daycare
- Summer day camp

Debit Cards

You will receive a debit card that can be used to pay for eligible expenses. However, if a purchase amount does not match a copay amount, you will be asked to substantiate a claim. If you do not respond to the request, your debit card will be deactivated. If you have a current debit card that is not expired and are electing to enroll, you may continue to use the card you have. If it is expired, you will be sent a new one when AmeriFlex receives your enrollment election. ***You can also submit a paper claim for reimbursement and have the amount deposited into your checking or savings account.***

Rollover Provision

King's College continues to include the rollover provision allowing up to $500 of unused Medical FSA funds from 2015/2016 to rollover into their 2016/2017 account with no restriction for accessing those funds in 2015/2016.

Run Out Claims: Employees have 60 days after the end of the plan year to submit for expenses incurred in via a paper claim.

To check your balance: Visit www.flex125.com OR Call Customer Service at 888-868-FLEX (3539)

See the Difference		
	With FSA	**Without FSA**
Income Before Taxes	$25,000	$25,000
Pre-Tax Expenses (FSA Election)	($1,000)	-$0
Taxable Income	$24,000	$25,000
Taxes (15%)	($3,600)	($3,750)
After Tax Expenses (Medical Expenses)	$0	($1,000)
Take Home Pay	**$20,400**	**$20,250**

To Enroll in the FSA, Please Fill Out and Return the Form on the Next Page

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Company Name: ______________________ **Location:** ______________

Employee Name: ______________________ **SSN:** ______________

Employee Email Address: ______________________

Home Address: ______________________

City: ______________ **State:** ________ **Zip:** ________

Telephone: ______________ **Plan Year:** ________ **through** ________

Date of Birth: ________ **Date of Hire:** ________ **Effective Date:** ________

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year or during such portion of the year as remains after the date of this agreement . I understand that If I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay non-reimbursable medical, dependent care, and/or commuter expenses if any with after-tax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

MEDICAL FLEXIBLE SPENDING ACCOUNT

Full Flexible Spending Account — Per pay contribution ________ Date of first payroll ________

________ Maximum ANNUAL Contribution — Annual contribution ________ Number of remaining pays ________

Limited Purpose Flexible Spending Account — Per pay contribution ________ Date of first payroll ________

________ Maximum ANNUAL Contribution — Annual contribution ________ Number of remaining pays ________

DEPENDENT CARE SPENDING ACCOUNT

Per pay contribution ________ Date of first payroll ________

________ Maximum ANNUAL Contribution — Annual contribution ________ Number of remaining pays ________

COMMUTER REIMBURSEMENT ACCOUNT

PARKING — Per pay contribution ________ Date of first payroll ________

________ Maximum MONTHLY Contribution — Annual contribution ________ Number of remaining pays ________

TRANSIT — Per pay contribution ________ Date of first payroll ________

________ Maximum MONTHLY Contribution — Annual contribution ________ Number of remaining pays ________

ADOPTION ASSISTANCE

Per pay contribution ________ Date of first payroll ________

________ Maximum ANNUAL Contribution — Annual contribution ________ Number of remaining pays ________

I UNDERSTAND THAT:

1 My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election . Note: This does not apply to Commuter Reimbursement Accounts.

The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is sub ect to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan s .

By signing this form I agree to the terms and procedures listed herein.

☐ I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.

____

Employee Signature Date

Cut on dotted line

AMERIFLEX® **FSA ENROLLMENT**/continued

ADDITIONAL CARDS only applicable if your employer has chosen this option

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meets the IRS eligibility guidelines below:

1 For federal tax purposes, a spouse includes all legally married same-sex or opposite-sex spouses, regardless of state residence.
A dependent generally includes any relative of the participant for whom the participant provides over half of their support for the calendar year. A relative includes children, parents, stepchildren, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be a certain age or infirmity they need only to be persons for whom the participant has provided over half of their support.

Spouse Name: ______________________________

Address to issue card: ______________________________

Telephone: ______________ Soc. Sec. Number: ______________ Date of Birth: ______________

All dependents must be age 18 or over in order to receive the AmeriFlex Convenience Card®. If you previously added a dependent onto your plan, they will automatically be linked each year. It is your responsibility to add and/or remove dependents as needed. To add additional dependents or to remove dependents, please complete the section below.

Add ☐ | Term ☐ Dependent Name: ______________________________

Address to issue card: ______________________________
If different from participant

Telephone: ______________ Soc. Sec. Number: ______________ Date of Birth: ______________

Add ☐ | Term ☐ Dependent Name: ______________________________

Address to issue card: ______________________________
If different from participant

Telephone: ______________ Soc. Sec. Number: ______________ Date of Birth: ______________

Each AmeriFlex Convenience Card® is issued for a term of three years. Remember that existing cardholders will not receive a new card unless the current card is scheduled to expire. Cards will simply be reloaded for the next plan year with your new election. Upon expiration, AmeriFlex will automatically issue new cards to participants who re-enroll in the new plan year. For new participants, your AmeriFlex Convenience Card® will be sent to your home adress in a plain white envelope.

AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS

I, hereby, authori e AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my bank account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

Depository Name: ______________ Account Name: ______________

City: ______________ State: ______________ Zip: ______________

Routing Number: ______________ Account Number: ______________
always nine digits

CHECK EXAMPLE
⑆123456789 ⑆0000123456 ⑆1234
ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

SELECT ONE: ☐ Checking Account ☐ Savings Account
If you would prefer, please attach a voided check.

The authori ation is to remain in full force and effect until the ADMINISTRATOR has received written notification from the employee named above of the termination in such time and in such manner as to afford the ADMINISTRATOR and DEPOSITORY a reasonable opportunity to act on it.

Date: ______________ Signature: ______________________________

Upon receipt, the Federal Reserve re uires 1 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.

It may take up to business days to have your reimbursements appear in your account, depending upon the automated clearing house utili ed by your bank. e suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

Cut on dotted line