

Participation and Salary Reduction Agreement
Talbot County Public Schools
Plan year: September 1, 2011 through August 31, 2012

I. Participant Identification (please print or type)

Participant Name: _____ **Social Security Number:** ____/____/____

Address: _____ **DOB:** ____/____/____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

II. Agreement to Participate and Salary Reduction Agreement

Please check below your benefit choices. Sign and date the form and return to the Benefits Coordinator.

Check the boxes for the benefits you are selecting and indicate the amount of salary reduction for each pay period for the Medical Flexible Spending Account and Dependent Care Flexible Spending Account.

I hereby authorize my employer to reduce my cash compensation as indicated below for each pay period during the Plan Year following the date of this agreement.

Flexible Spending Arrangements

Dependent Care FSA
(not to exceed \$5000.00 annually; \$208.33 per pay)

Salary Reduction Per Pay	X	Number of Pay periods	=	Annual Election
_____		_____		_____

Medical Expense FSA
(not to exceed \$2500.00 annually; \$104.16 per pay)

_____		_____		_____
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I understand that this election form cannot be revoked or changed during the plan year, unless there is a change in my family status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse) which justifies the revocation or change. I understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years. If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amounts will be the property of the employer. I understand that I will be required to submit a separate written notice to my Employer to enroll in a Limited Plan if I have a family member who is making contributions to a Health Savings Account (HSA) under section 223 of the Internal Revenue Code.

I certify that the card will only be used for eligible medical expenses (and if applicable eligible dependent care expenses) at eligible providers. I further certify that the amount of eligible expenses is not reimbursable from any other source, nor will I attempt to be reimbursed from any other source. I will maintain substantiation for all expenses and where required provide applicable substantiation upon request. If I cannot produce adequate substantiation, I must repay the Plan for such an expense. Failure to repay the Plan will result in the moneys being withheld from my pay. If I terminate employment or participation in the plan, I will return the debit card to my employer.

I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Participant's Signature

Date

Agreed and accepted by
The Employer's Representative

Date

(Admin. Only): Effective Date: ____/____/____
1st Withholding: ____/____/____



MEDICAL Flexible Spending Account
Request for Reimbursement

TCPS

SECTION A: Employee Information (please print clearly in ALL CAPITAL letters)

Plan Year: 9.01.11 - 8.31.12

Name: _____ Employee ID: _____
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: **Talbot County Public Schools**

Email: _____ Phone Number: _____

Address: _____

Check here if new address

SECTION B: Claim information and Signature

PLEASE READ CAREFULLY: I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I certify that any prescriptions drug expenses are for medical care and not cosmetic purposes. I understand that I am responsible for the accuracy of the information related to this expense. I have not and will not seek to be reimbursed through any other health plan coverage for any of the expenses listed below. I further declare that I will not deduct any of the reimbursed medical expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: \$ _____ Number of pages sent (do NOT fax a cover sheet): _____

Participant Signature: _____ Date: _____

SECTION C: Medical Claim details (please print clearly in ALL CAPITAL letters)

- 1) Provider: _____ Date of Service: _____ Amount: _____
- 2) Provider: _____ Date of Service: _____ Amount: _____
- 3) Provider: _____ Date of Service: _____ Amount: _____
- 4) Provider: _____ Date of Service: _____ Amount: _____
- 5) Provider: _____ Date of Service: _____ Amount: _____
- 6) Provider: _____ Date of Service: _____ Amount: _____
- 7) Provider: _____ Date of Service: _____ Amount: _____
- 8) Provider: _____ Date of Service: _____ Amount: _____

TOTAL AMOUNT OF MEDICAL REIMBURSEMENT REQUESTED: \$ _____

FAX THE CLAIM TO:

888-510-4218

or EMAIL TO:

Claims@hfsbenefits.com

If mailing, please keep the originals for your records.

Mailed claims can be sent to:
4 North Park Drive, Suite 500
Hunt Valley, MD · 21030-1550



BEFORE SENDING MAKE SURE YOU ...

- Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement.
- Itemize all expenses on the claim form. List the provider name, date of service (the date the service was INCURRED), and the amount of each expense. Please use additional sheets if necessary. Do NOT indicate 'See attached' or 'Various' in any field.
- Attach proof of expense (invoice, receipt, EOB, etc.) in the order you have them listed above.
- Receipts, invoices, etc. must show the date, type and amount of service/product purchased.
- Circle the date and the amount requested on each receipt. Do NOT highlight.



BEFORE SENDING MAKE SURE YOU DO NOT...

- Send in cancelled checks or credit card receipts. These are NOT acceptable.
- Send in a receipt listing 'BALANCE DUE' or 'BALANCE FORWARD'.
- Fax in your claim multiple times.

View your account online at www.hfsbenefits.com



DEPENDENT CARE Flexible Spending
Account Request for Reimbursement

TCPS

SECTION A: Employee Information (please print clearly in ALL CAPITAL letters)

Plan Year: **9.01.11 - 8.31.12**

Name: _____ Employee ID: _____
(FIRST NAME LAST NAME) (This may be your SSN or employer assigned number)

Employer: **Talbot County Public Schools**

Email: _____ Phone Number: _____

Address: _____
 Check here if new address

SECTION B: Claim information and Signature

PLEASE READ CAREFULLY: I certify that the expenses listed below have been incurred by me, my spouse and/or my eligible dependents during the plan year and while I was a participant in the plan. To the best of my knowledge all expenses below are eligible under the plan. I declare that I will not deduct any of the reimbursed Dependent Care expenses listed below from my federal, state or local tax returns.

Total amount of this claim requested: \$ _____ Number of pages sent (do NOT fax a cover sheet): _____

Participant Signature: _____ Date: _____

SECTION C: Dependent Care Claim details (please print clearly in ALL CAPITAL letters)

1.	Period of Dependent Care FROM DATE:	To Date:	
	Provider Name:	Age of Dependent:	
	If no receipt is available, please have caregiver sign here:	Amount:	
2.	Period of Dependent Care FROM DATE:	To Date:	
	Provider Name:	Age of Dependent:	
	If no receipt is available, please have caregiver sign here:	Amount:	
3.	Period of Dependent Care FROM DATE:	To Date:	
	Provider Name:	Age of Dependent:	
	If no receipt is available, please have caregiver sign here:	Amount:	

Total Amount for which I am requesting reimbursement: \$ _____

<p>FAX THE CLAIM TO: 888-510-4218</p> <p>or</p> <p>EMAIL TO: Claims@hfsbenefits.com</p> <p>If mailing, please keep the originals for your records. 4 North Park Drive, Suite 500 · Hunt Valley, MD · 21030-1550</p>	<p>STOP BEFORE SENDING MAKE SURE YOU ...</p> <ul style="list-style-type: none"> • Complete this form in its entirety. Failure to complete all sections can result in a delay in processing your reimbursement. • Attach proof of expense (receipt, invoice, etc.) If no receipt is available, the caregiver must sign where indicated. • Keep originals for your records. <p>STOP BEFORE SENDING MAKE SURE YOU DO NOT...</p> <ul style="list-style-type: none"> • Send in cancelled checks or credit card receipts. These are NOT acceptable. • Fax in your claim multiple times. • Send in Dependent Care Claims prior to services being incurred.
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View your account online at www.hfsbenefits.com