Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work℠

Unreimbursed Medical/Dependent Care FSA Election Form

(See worksheet on back to assist you in determining your election for next year.)

Please return this form to your employer.

S.S. # | __ | __ | __ | - | __ | __ | - | __ | __ | __ | __ |

Employee Name (print) ____________________

Home Address ____________________

City ____________________ State __________ Zip Code __________

E-mail address ____________________

Home Phone #: (   ) ______________ Work Phone #: (   ) ______________

Date of Hire: ______________ Date of Birth: ______________

Employer Name: ____________________

Unreimbursed Medical

❑ I elect to participate in the Unreimbursed Medical Flexible Spending Account. I direct and authorize my employer to reduce my annual salary for the plan year __________ by $__________. I understand that my salary will be reduced in **equal amounts** from my regular paycheck.

❑ I elect **not** to participate at this time.

Dependent Care

The total amount I can deposit into my Dependent Care Flexible Spending Account cannot exceed the lesser of $5,000 ($2,500 for a married person filing separately) or my spouse's earned income. **If my spouse does not work and is not disabled or a full-time student, I cannot participate in the Dependent Care Spending Account.**

❑ I elect to participate in the Dependent Care Flexible Spending Account. I direct and authorize my employer to reduce my annual salary for the plan year __________ by $ __________ (maximum $5,000 – see above). I understand that my salary will be reduced in **equal amounts** from my regular paycheck.

❑ I elect **not** to participate at this time.

I understand the following: This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g. legal separation, divorce, or marriage; birth or legal adoption of a child; death of a dependent; change in work status for you or your spouse; or change in cost or coverage for Dependent Care).

I can continue to file claims for expenses incurred during the plan year until three months following the end of the plan year. Funds not used during the plan year are forfeited. In effect, I must "use it or lose it."

YOUR SIGNATURE ______________________________ DATE ______________

Services and Products may be provided by Horizon Blue Cross Blue Shield of New Jersey, an independent licensee of the Blue Cross and Blue Shield Association.

Plan Enhancements

Interactive Web site

Horizon Blue Cross Blue Shield of New Jersey Web site can be reached at <www.HorizonBlue.com/fsa>.

- **Online Worksheets**
  - Dependent Care vs. Federal Tax Credit.
  - Unreimbursed Medical Worksheet.
- **Online Claim Entry Module**
  - Submit your Unreimbursed Medical and Dependent Care claims over the Internet (Available now!).
- **Downloadable Forms**
  - Download and print Flexible Spending Account forms directly to your PC: FSA Election Form, Direct Deposit Enrollment, Change in Status and more
- **Online Account Balance Inquiry**
  - Receive up-to-date account balance information over the Internet.
- **Online Claim List**
  - Provides information on the most recent claims submitted.
- **Online Payment List**
  - Details the most recent FSA payments issued from your account(s).
- **Direct Deposit**
  - Participants will be able to elect direct deposit of FSA reimbursements into a checking or savings account.

Worksheet

Unreimbursed Medical FSA

List the amount you spent for:	Prior Year Actual Expenses	Projected Expenses
Deductibles/coinsurance	$ ________	$ ________
Vision care/LASIK eye surgery (eye exams, contact lenses solutions and eyeglasses)	$ ________	$ ________
Routine exams if not covered by insurance (Ob/Gyn, well visits, etc.)	$ ________	$ ________
Prescription drugs (including birth control) (Does not include cosmetic prescriptions)	$ ________	$ ________
Certain over-the-counter drugs*	$ ________	$ ________
Travel costs related to medical care	$ ________	$ ________
Other	$ ________	$ ________
List the amount you spent for out-of-pocket dental expenses:		
Examinations and cleanings	$ ________	$ ________
Fillings, crowns and bridges	$ ________	$ ________
Orthodontics/periodontics	$ ________	$ ________
Dentures/implants/X-rays	$ ________	$ ________
	Total $ ________	Total $ ________
Projected Unreimbursed Medical FSA Deposit	$ ____________________	

Dependent Care FSA

	Prior Year Actual Expenses	Projected Expenses
Payments made for dependent care services provided in your home	$ ________	$ ________
Day care center/nursery school	$ ________	$ ________
Before- or after-school care/summer day camp facility	$ ________	$ ________
	Total $ ________	Total $ ________
Projected Dependent Care FSA Deposit	$ ____________________	

* Visit our Web site at www.HorizonBlue.com/fsa to download a detailed listing of eligible over-the-counter items.

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