



TRUSTEES OF HAMPSHIRE COLLEGE
NH FLEXIBLE BENEFIT PLAN ENROLLMENT FORM
 PLAN YEAR: JANUARY 1, 2012 TO DECEMBER 31, 2012

A. Employee Information Please Print Clearly! Instructions on Back

Name: _____ Social Security Number (Required): _____
 Home Address: _____
 Check if New: _____
 City: _____ State: _____ Zip Code: _____ Day Phone: _____
 E-mail Address: _____ Date of Birth: _____

B. Flexible Benefit Plan Pre-tax Elections

1. Health Care Reimbursement Account Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Plan Year for "the diagnosis, cure mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body". **Please note that legislation recently signed into law, mandates that OTC drugs and medicines (other than insulin) will only be eligible for reimbursement under health FSA with a doctor's prescription effective January 1, 2011.**

\$ _____	X	_____	=	\$ _____	Maximum Election allowed \$5,000
Your Contribution Per Pay Period		# of Pay Periods		Total Election	

2. Dependent Care Assistance Account Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

\$ _____	X	_____	=	\$ _____	Maximum Election allowed \$5,000 (\$2,500 if married filing separately)
Your Contribution Per Pay Period		# of Pay Periods		Total Election	

C. FlexExpress® Debit Card The FlexExpress Card® is optional. If you and/or your dependents have debit cards, they will automatically be reactivated unless you indicate below that you do not want a card. Otherwise, please indicate your selection below. Annual Fees: Primary Card - Paid by Waived, Cost \$0, Dependent Cards - Paid by Waived, Cost \$0 each.

	* If you and/or your dependents have debit cards, they will be automatically reactivated for your renewal. Otherwise, please select from below:		NO action required.
Check One:	<input type="checkbox"/>	I am a new participant to this plan and would like a NEW debit card.	This is for brand new participants only, if you already have a card, selecting this option will automatically <u>inactivate</u> your existing card.
	<input type="checkbox"/>	I have a card that was lost, stolen or damaged and would like a replacement card.	Selecting this option will <u>inactivate</u> your existing card.
	<input type="checkbox"/>	I do NOT want a FlexExpress Card.	Your default reimbursement method will be check unless the direct deposit information below is completed.

Additional Card Information: List your spouse or dependents (over age 18) you would like to order a FlexExpress® Card for. This is for your legal dependents only. Domestic/Civil Union Partners are not IRS eligible dependents in most cases. If your dependents already have a card, it will remain active until you indicate to inactivate it below.

Full Name	Social Security Number	Date of Birth	New or Inactivate Card
1.			___New ___Inactivate
2.			___New ___Inactivate

D. Direct Deposit Authorization If you would like non-FlexExpress® reimbursements to be direct deposited to your bank account (rather than receiving paper checks) fill out the information below EACH PLAN YEAR AND attach a voided check.

Bank Name: (See #1 on sample) Routing Number - 9 digits (See #2 on sample): <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	Account Number (See #3 on sample): <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	SAMPLE
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E. Signatures By signing below, I agree to all of the Terms and Conditions stated on the opposite side of this form.

Employee Signature (required):		Date:	
Employer Acceptance (required):		Effective Date:	

Enrollment Form Instructions

Section A	EMPLOYEE INFORMATION - Please print your name and complete address clearly. Your phone number and e-mail address will be used only to communicate with you with regards to this plan. It will not be distributed to any other organization or used for marketing purposes in any way. Statements of your account balance and activity will be sent via e-mail whenever possible. Please understand that this is an employee account and due to federal and state laws we cannot release detailed information to anyone other than the participant, this also includes your spouse and/or dependent(s). Please contact our office for further information.
Section B	FLEXIBLE BENEFIT PLAN PRE-TAX ELECTIONS <ol style="list-style-type: none"> 1. Health Care Reimbursement Account - Carefully consider how much money you would like to set aside each pay period during the Plan Year to pay for your family's eligible out-of-pocket medical expenses. Make sure you read your Summary Plan Description and/or the Health Care brochure to fully understand how the plan works. 2. Dependent Care Assistance Account - Carefully consider how much money you would like to set aside each pay period during the Plan Year to cover the expenses you will incur to care for your eligible dependents while you and your spouse (if applicable) are gainfully employed. Make sure you read your Summary Plan Description and/or the Dependent Care brochure to fully understand how the plan works.
Section C	FlexExpress® Debit Card - If you and/or your dependents currently have FlexExpress® Debit Cards, they will be automatically reactivated each year unless you indicate to inactivate them. New participants can order cards for themselves as well as their dependents using the debit card section on the front of the form. Cards may also be inactivated using this form if necessary.
Section D	Direct Deposit Authorization - Claims that are faxed, mailed or filed on-line are normally reimbursed by sending you a paper check. If you would like your reimbursements sent directly to your checking or savings account via Direct Deposit, fill out this section and attach a voided check (for checking) or deposit slip (for savings). Confirmations are sent via email and will show current transaction information as well as available funds in the account.
Section E	Signatures - After you have completely filled out this form and carefully read the following Terms and Conditions please sign and date then return the enrollment form to the HR office as applicable. Employers must review the elections and sign that the employee meets the eligibility requirements.

Flexible Benefit Plan Terms and Conditions

I UNDERSTAND THAT:

- I cannot change this election during the Plan Year unless I have a qualifying change in family status.
- My Social Security benefits may be reduced by this election due to the pre-tax treatment of these expenses.
- I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts *cannot* be reimbursed from any other source and *must* be incurred during the Plan Year. Any money unclaimed from my reimbursement account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back.
- I may have an additional 2½-month Grace Period at the end of the current plan year to incur eligible expenses for reimbursement. See your Flexible Benefit Plan Summary Plan Description for more details.
- I understand that Flexible Benefit Plans are to reimburse expenses incurred by my legal dependents or myself only. *Domestic/Civil Union Partners are not IRS eligible dependents in most cases.*
- Health Care Reimbursement Accounts will be reimbursed up to the annual election (minus previous payments). Dependent Care Assistance Accounts will be reimbursed up to the balance currently credited to the account.
- ***The Health Care Reform legislation signed into law by the President March 2010 impacts over the counter (OTC) purchases with Health Care Flexible Spending Accounts, Health Reimbursement Arrangements and Health Savings Accounts beginning January of 2011. OTC drugs and medicines will only be eligible with a prescription from a doctor. Because these items now require a doctor's prescription, these items can no longer be purchased using the debit card. Participants may still be able to receive reimbursement for the item using their Health FSA, HRA or HSA; however they must send in a claim form accompanied by the prescription from their doctor. All non-prescription OTC drugs and medicine expenses need to be incurred (purchased) prior to January 1, 2011, either by card or claimed using a claim form and receipt, to be eligible for reimbursement without a doctor's prescription. More information will be provided as available.**
- 1. **FlexExpress® Card:** The FlexExpress® Card is to be used only to pay for IRS eligible health and/or dependent care expenses. It cannot be used to purchase any items or services not specifically approved by IRS guidelines.
 2. For expenses paid with the FlexExpress® Card I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits.
 3. Any OTC drug or medicine incurred prior to January 1, 2011 will not require a prescription for reimbursement and can be purchased using the debit card. Any OTC drug or medicine expense incurred on or after January 1, 2011 will require a prescription for reimbursement and the debit card will no longer work for those drug or medicine OTC expenses.
 4. The IRS requires me to keep documentation of all my expenses the card is used for, and supply them to Benefit Strategies if requested.
 5. Misuse of the FlexExpress® Card will result in permanent revocation and repayment of ineligible expenses.