Linn County FSA plan

LIST ELIGIBLE FAMILY MEMBERS:

Complete this section if you have elected "Yes" to participate in the Medical or Dependent Care Plans, and you have eligible dependents (spouse, children, parents) for whom you may be submitting claims for reimbursement.

NOTE: Administratively, we define "eligible dependent" to be any legal relative regardless of whether that person is living with you in your home for whom you provide half of their support. Further, an eligible dependent may be any child of minority age not related to, but living with you under a custodial care arrangement. An eligible dependent does not have to be claimed on your personal tax return.

Please list spouse if applicable, then dependents in birth order.

Relationship	Name (Last Name if Different from Yours)	Birth Date Mo/Day/Yr		
Spouse				

Please answer the following questions in their entirety:

1. Are you or any member of your family covered by a High-Deductible Health Savings Account (HSA)? Yes_____ No_____
2. Are you or any member of your family "double covered" where there is more than one health, dental or vision policy covering them? If yes please indicate who is double covered and how? _____. Yes_____ No_____
3. Are you currently covered under another flexible spending plan with your spouse's employer? Yes_____ No_____

REIMBURSEMENT OPTIONS

How would you like to be reimbursed?

☐ Check delivered by mail

☐ Electronic Fund Transfer (COMPLETE THE AUTHORIZATION BELOW IF YOU HAVE NOT ALREADY DONE SO)

If you choose EFT, how would you like to be notified of reimbursement?

☐ Benefit Statement delivered by mail

☐ PDF Benefit Statement delivered by email

Email Address:_____

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS

Any reimbursements for your flexible spending account will be directly deposited into your savings/checking account. To guarantee the reimbursement will be made to the correct checking/savings account it is **VERY IMPORTANT** you attach a voided check with the word "VOID" written across the face of the check, to this form.

I (we) hereby authorize P.R.I.M.E. Benefit Systems, Inc., to initiate credit entries to my (our) bank account named below, and to initiate debit entries solely to correct any errors. Written notification will be made. (Please note that the employee must be an owner on the account).

Bank Name:_____

Bank Address:_____

City:_____ State:_____ Zip:_____

Routing Number:_____ Account Number:_____

Type of Account: ☐ Savings or ☐ Checking

This authority is to remain in full force and effect until P.R.I.M.E. Benefit Systems, Inc. and my bank have received written notification from me (or either of us) of its termination in such time and in such manner as to afford P.R.I.M.E. Benefit Systems, Inc. and Depository a reasonable opportunity to act on it.

By my signature below, I agree that if my bank information changes during the course of the plan year, I will immediately submit the most recent "voided" check to P.R.I.M.E. Benefit Systems, Inc. so the proper changes can be made. I acknowledge that failure to submit current bank information will cause a delay in my claim reimbursement.

_____ _____

Signature Date

REMEMBER YOU MUST RETURN THIS FORM EVEN IF YOU DECIDED NOT TO PARTICIPATE