BARTON COMMUNITY COLLEGE

FCMI FREEDOM CLAIMS MANAGEMENT, INC.
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Group #: 911377

☐ GB/ Fort Riley ☐ Leavenworth & Out of State

EMPLOYEE ENROLLMENT/CHANGE FORM

1. REASON FOR COMPLETING THIS FORM

Check One:		**DATE TO BE EFFECTIVE:**
	New Hire	Hire Date:
	Termination	Term Date or Last Day Worked:
	Change Personal Information – Complete Changes Below	

QUALIFYING EVENTS

Check One:	Qualifying Event Date:

DATE TO BE EFFECTIVE:

	Marriage		Open Enrollment		Loss of Dependent Status		Reduction of Work Hours
	Divorce		Separation		Other Special Enrollment Event		Other:
	Birth		Adoption		Loss of Other Coverage		

2. PERSONAL INFORMATION – All Information is Required

Employee Name:				Tobacco Use		Yes	No
SSN:		Date of Birth:			Gender:		
Address:							
City:		State:		Zip:			
Phone:		Marital Status:			Occupation:		
Email:							

3. PLAN SECTION – Medical – Dental - Vision

Medical:		**I Elect/Change (Select Tier)**		**I Decline (Choose Reason)**
		Employee Only		I am covered as a dependent by another plan
		Employee + Spouse		I am covered under TriCare
		Employee + Child(ren)		Spouse/children are covered by another plan
		Family		Myself or spouse is enrolled in Medicare
				Other:

Dental:		**I Elect/Change (Select Tier)**		**I Decline (Choose Reason)**
		Employee Only		I am covered as a dependent by another plan
		Employee + Spouse		Spouse/children are covered by another plan
		Employee + Child(ren)		Other:
		Family		

Vision:		**I Elect/Change (Select Tier)**		**I Decline (Choose Reason)**
		Employee Only		I am covered as a dependent by another plan
		Employee + Spouse		Spouse/children are covered by another plan
		Employee + Children		Other:
		Family		

4. PLAN SECTION – Flexible Spending Account (FSA)

Healthcare		**HEALTH CARE FSA: Maximum Annual Contribution is $3,200.**		
		Select One:		
		I elect to enroll in the Health Care FSA for medical, vision and/or dental expenses	$	Contribution per pay period
		Waive	$	Contribution per plan year
Dependent Care		**DEPENDENT CARE FSA (Daycare Reimbursement): $5,000 Plan Year Maximum; $2,500 for married filing separately.**		
		Select One:		
		I elect to enroll in the Dependent Care FSA to be used for qualified dependent care expenses	$	Contribution per pay period
		Waive	$	Contribution per plan year

Beneficiary Designation for FSA

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek reimbursement under the terms of the plan. I therefore designate as my beneficiary under the plan

Name:		Relationship:	
Address:			
City:		State:	Zip Code:

I understand that I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I experience a qualifying event (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). The plan administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it is advisable to satisfy certain provisions of the Internal Revenue Code. The authorized redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans. Any remaining account balances following the end of my plan's designated grace period will be forfeited. By participating in one of the plan options defined above, I acknowledge my Social Security benefits may be slightly reduced.

Please complete the table below for each dependent that will be covered.

List all eligible dependents you want covered under this policy (spouse, children, step-children or children of legal guardianship). Unless handicapped, to qualify for coverage a child must be under the age of 26.

Relationship (Spouse, Common Law Spouse, Child, Stepchild, Adopted Child, Legal Guardianship)	Last Name	First Name	SSN:	Birth Date	Gender M/F	Medical Check One	Dental Check One	Vision Check One
						Yes	Yes	Yes
						No	No	No
						Yes	Yes	Yes
						No	No	No
						Yes	Yes	Yes
						No	No	No
						Yes	Yes	Yes
						No	No	No
						Yes	Yes	Yes
						No	No	No
						Yes	Yes	Yes
						No	No	No
						Yes	Yes	Yes
						No	No	No

5. OTHER COVERAGE

Do you or any other dependents have other group medical/dental coverage: YES___ NO___

Employee	***Name of insurance company***	***Medical/Dental (circle all that apply)***	***Group / Individual Medicare A/B / Medicaid (circle one)***
Spouse	***Name of insurance company***	***Medical/Dental (circle all that apply)***	***Group / Individual Medicare A/B / Medicaid (circle one)***
Dependent	***Name of insurance company***	***Medical/Dental (circle all that apply)***	***Group / Individual Medicare A/B / Medicaid (circle one)***

6. ACKNOWLEDGMENT AND AUTHORIZATION OF COVERAGE

As an employee, you may participate in the premium expense benefit programs in the list below. Before you can participate, you must complete the appropriate enrollment form(s) for each of the benefits elected. If you enroll in any of the premium expense benefit programs, then your premiums will automatically be deducted on a pre-tax basis each pay period unless you notify the employer of such decision to pay for the benefits on an after-tax basis. Payroll deductions on an after-tax basis will result in payment of higher Social Security and federal unemployment taxes than if you participate on a pre-tax basis. Once elected, you cannot change your election for these premium expense benefit programs until the next open enrollment period or until a qualifying event occurs. Complete the table below by writing the amount of your deduction(s) in the appropriate pre-tax or after-tax column below.

BENEFIT	PER PAYCHECK – PRETAX DEDUCTION	PER PAYCHECK AFTER-TAX DEDUCTION
Medical	$	$
Dental	$	$
Vision	$	$
Accident Insurance	$	$
Cancer Insurance	$	$

I acknowledge that I have been given the opportunity to enroll in the premium expense benefit plans, HCFSA and DCFSA. I have enrolled for the premium expense plans for which I am eligible for coverage. I authorize my employer to reduce my pay each pay period and deposit into my employee plan account(s), in equal deposits, the amount necessary to satisfy the benefits I have elected on this agreement according to the rules applying thereto. I acknowledge that my actual take-home pay may be higher or lower depending on the coverage I select. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. If I chose premium expense benefits on an after-tax basis instead of a pre-tax basis, I understand that my Social Security and federal unemployment deductions may be higher than if I chose to pay them on a pre-tax basis.

I understand that:
I cannot change or revoke any of my elections on this salary redirection agreement at any time during the Plan Year unless I experience a qualifying event, and my election is consistent with such event change. HCFSA amounts in excess of $500 that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year. Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my premium expense benefits then in effect for the new Plan Year but not my HCFSA or DCFSA benefits. HCFSA and DCFSA elections must be made each Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the premium expense benefit option.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give Freedom Claims Management, Inc. such information. A photographic copy of this authorization shall be as valid as the original and valid from the date signed for the duration of 1 year.

Employee Signature: _____ **Date:** _____

7. WAIVER OF COVERAGE

By declining coverage, I understand that I have received and understand the Special Enrollment Notice. I also understand that if I declined coverage because of other insurance and it is NOT listed in the decline reason, that I will not be eligible to enroll under this plan until open enrollment.

Employee Signature: _____ **Date:** _____