

BENEFIT YEAR 2015



Administrator
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**FLEXIBLE BENEFIT
ENROLLMENT FORM**

Name: _____

Employee Number: _____

PRE-TAX PREMIUMS

I authorize withholding of my medical and/or dental premiums on a pre-tax basis from my paycheck to pay for coverage offered by the City of Winona.

Yes – Deduct premiums before tax is calculated. No - Deduct premiums after-tax.

LIMITED - MEDICAL/DENTAL FLEXIBLE SPENDING ACCOUNT (Plan Year Max. of \$2,500 Limited & Full Combined)

I participate in a Health Savings Account. I understand that my participation in the Flexible Spending Account must be limited to only Preventive, Dental and Vision expenses.

I authorize the following amount to be deducted from my paycheck and placed in my Limited Medical/Dental Expenses Account:

\$ _____/year which is \$ _____/paycheck

(Enter either the amount for the year or per paycheck. The other will be calculated for you.)

I do not wish to participate in the Limited Medical/Dental Expense Account.

FULL - MEDICAL/DENTAL FLEXIBLE SPENDING ACCOUNT (Plan Year Maximum of \$2,500 Limited & Full Combined)

I authorize the following amount to be deducted from my paycheck and placed in my Medical/Dental Expense Account:

\$ _____/year which is \$ _____/paycheck

(Enter either the amount for the year or per paycheck. The other will be calculated for you.)

I do not wish to participate in the Full Medical/Dental Expense Account.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FOR DAY CARE EXPENSES) (Plan Year Maximum of \$5,000)

I authorize the following amount to be deducted from my paycheck and placed in my Dependent Care Expense Account:

\$ _____/year which is \$ _____/paycheck

(Enter either the amount for the year or per paycheck. The other will be calculated for you.)

I do not wish to participate in the Dependent Care Expense Account.

DEBIT CARD ELECTION: For use with HRA and Flex Expenses at point of purchase.

YES, please issue me a debit card NO, do not issue me a debit card. Cancel my debit card

I authorize my employer to make the above deductions from my paycheck on a pre-tax basis. I will be able to request reimbursement for withheld monies when I incur eligible expenses during the plan year in accordance with the plan documents. Unused flex dollars remaining in my account(s) at the end of the plan year will be forfeited.

Employee Signature _____

Date _____

FOR EMPLOYER USE ONLY

Effective Date: 01/01/2015 Received _____ By _____ DB _____