Advantage™
ADMINISTRATORS

PARTICIPATION FORM FOR THE FLEXIBLE BENEFITS PLAN

*Please Print

Participant Name _____ Employer _____

Date of Birth ___/___/___ Social Security No. _____ Employer ID _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Direct Deposit Yes _____ No _____ Checking _____ Savings _____

Routing Number _____ Bank Account Number _____

Flex Visa Card Yes _____ No _____

If yes: *I understand that the annual card fee is $15, which will be deducted from my flex account.
*I understand that two Flex Visa Cards have been, or will be, provided, both in my name.
*I understand that my spouse or dependent can sign and use the second card.

	Annual	Per Pay Period
1. Medical Flex Spending Account (Medical, Dental, Vision)	$ _____	$ _____

☐ **OPTIONAL**: My spouse has a High Deductible Health Plan (HDHP) and intends to make or receive contributions to a Health Savings Account (HSA). **As such, this election does not apply to expenses incurred by my spouse.**

or Limited Account (Dental, Vision, and Post-Deductible Only)	$ _____	$ _____

USE ONLY WHEN you or your spouse are making or receiving contributions to an HSA; this election will apply only to dental, vision, and post-deductible expenses for you, your spouse, and your dependents.

2.Dependent Care Expenses (Daycare)	$ _____	$ _____
3.Health Savings Account (if offered by your employer)	$ _____	$ _____

4.Agreement to Save on Insurance Premiums

☐ On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my election will automatically be adjusted to reflect that change.

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. My employer and I agree that my compensation will be reduced each pay period during the year by an equal portion of the benefit elections set forth above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand the Flexible Spending Amount will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I acknowledge that I have received, read and understand the Summary Plan Description.

Employee Signature _____ Date _____

To be completed by employer:
Effective Date if not renewal (mm/dd/yy) ___/___/___ First payroll date ___/___/___ Number of Payrolls for deduction _____

Advantage Administrators™, 2019

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Flex Benefit Plan WORKSHEET

Visit www.advantageadmin.com for a list of covered items

Now that you know about the many ways you can use pre-tax earnings to keep more of what you earn, take a moment to fill out this worksheet to determine how much money you'll save annually by participating in your employer's flex benefit plan.

Simply check off the items you wish to save for and budget how much you'll spend in the upcoming year on those products and services. Fill in the estimate in the space next to each item. Then add up each category and place those totals in the corresponding section below the checklist.

HEALTHCARE EXPENSES (estimated)

FOR EXPENSES NOT COVERED BY INSURANCE

- Co-pays to doctors & pharmacies $ _____
- Oxygen, insulin, syringes & supplies $ _____
- Dual Purpose Items (Letter of Medical Necessity is needed in order for these items to be flex eligible) $ _____
- Special schooling for disabled child $ _____
- Prescription drugs $ _____
- Wigs for hair loss caused by disease $ _____
- Office visits & checkups $ _____
- Reconstructive surgery (birth defect, disease) $ _____
- Prescribed sunglasses & eyeglasses $ _____
- Medical alert bracelet & fees $ _____
- Contact lenses, solutions & supplies $ _____
- Alcoholism & drug treatment $ _____
- Eye exams, surgery & LASIK $ _____
- Dental cleanings, fillings & x-rays $ _____
- Breast pump and related accessories $ _____
- Sealants, crowns, bridges & dentures $ _____
- Walkers, canes & wheelchairs $ _____
- Braces, invisalign, spacers & retainers $ _____
- Arches $ _____
- Wisdom teeth, implants & oral surgery $ _____
- Artificial limbs & braces $ _____
- Psychologist & psychiatrist fees $ _____
- Physical & speech therapy $ _____
- Obstetrics & fertility $ _____
- Hearing aids, batteries & exams $ _____
- Lab tests & body scans $ _____
- Chiropractic & podiatrist fees $ _____
- Travel & mileage to doctor or hospital, etc. $ _____
- Misc/Other $ _____

TOTAL OPTION 1 $ _____

DEPENDENT CARE EXPENSES (estimated)

SO YOU CAN WORK

- Nanny & babysitter $ _____
- Day camp $ _____
- Pre-K or nursery school $ _____
- Daycare for a disabled adult or child $ _____
- Before & after-school care $ _____
- Elder daycare for parent or dependent $ _____

TOTAL OPTION 2 $ _____

ESTIMATED ANNUAL EXPENSES AND TAX SAVINGS

TOTAL 1 _____ + TOTAL 2 _____ + Other _____ = $ _____

Save between 25% and 40% on FICA, federal & state income tax (in applicable states). x 36%

Based on national averages, you'll save 25% if your annual household earnings are less than $30,000, 36% if you earn $30,000 to $60,000, or 40% if you earn more than $60,000.

Federal and/or plan limits apply to all options. See your summary plan description for plan limits

YOU SAVE $ _____