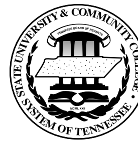
FBMC

Premier Benefits Solutions
Customer Care 1-800-342-8017 7 a.m.-10 p.m. ET



Tennessee Board of Regents Flexible Benefits Plan 2011 Plan Year Enrollment Form

PLEASE PRINT USING A BALLPOINT PEN.

LAST NAME	FIRST NAME	M	SOCIAL SECURITY NUMBER

WORK PHONE	HOME PHONE	HOME ADDRESS [STREET]	CITY	STATE	ZIP
( )	( )				

Enrollment Status:	DATE EMPLOYED	DEPT. CODE (Refer to list in your Reference Guide, available at **www.tbr.edu**)	EFFECTIVE DATE	PAY CHECK EFF. DATE: **(FOR OFFICE USE ONLY)**	PAYROLL FREQUENCY	E-MAIL ADDRESS
☐ New Enrollment ☐ Re-enrollment					☐ 12 ☐ 24 ☐ 26	

Automatic Conversion of State Group Medical and Dental Premiums: Your State Group Medical and Dental Premiums will automatically be paid through tax-free salary reduction. If you do not wish to have your Group Medical and Dental Premiums paid on a pre-tax basis, you must complete the WAIVER box at the bottom of this form.

NEW ELECTIONS MUST BE FILED FOR THE 2011 PLAN YEAR

Flexible Spending Accounts Complete the worksheets provided in your Reference Guide (available at **www.tbr.edu**) before deciding on the amount(s) to be entered in the sections below. If you have questions, consult your Reference Guide, or call FBMC Customer Care at 1-800-342-8017. You may also contact FBMC Customer Care at **www.myFBMC.com**.

In Box #1, indicate the total dollar amount you elect to contribute for the 2011 Plan Year. In Box #2, indicate the number of regular payroll checks you expect to receive during the 2011 Plan Year (consult your payroll office if you are unsure of how many checks you will receive). In Box #3, indicate the reduction amount per pay period.

MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT

Maximum allowable annual contribution is $3,600 per employee.

Box #1 Total 2011 Plan Year Dollar Amount		______
Box #2 Number of Regular Paychecks Expected	÷	______
Box #3 Reduction Per Regular Paycheck	=	______

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

TAX FILING STATUS **[PLEASE CHECK ONE]:**

☐ Married, filing separately [maximum - $2,500] ☐ Married, filing jointly [maximum - $5,000] ☐ Single, head of household [maximum - $5,000]

Box #1 Total 2011 Plan Year Dollar Amount		______
Box #2 Number of Regular Paychecks Expected	÷	______
Box #3 Reduction Per Regular Paycheck	=	______

IMPORTANT

- I understand that this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- **I understand that my State Group Medical and Dental Premiums will be paid automatically through tax-free salary reduction unless I complete the waiver section below.**
- I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above.
- I understand the contribution to my Social Security account will be reduced, since contributions will be based on my income after reduction.
- I understand that any amount remaining in any Flexible Spending Account that is not used during the plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA account cannot be used to reimburse expenses covered by another account.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax returns.
- I understand that the funds in the FSA account can only be paid out to reimburse payment of eligible expenses actually incurred during the plan year.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved change in status, within 90 days of a qualifying event.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year, unless otherwise provided by law.
- I understand that I may be asked by the IRS to provide the FEI number of my daycare provider.
- **I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any other source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.**

THE TENNESSEE BOARD OF REGENTS RESERVES THE RIGHT TO REDUCE SALARY REDUCTION ELECTIONS AS MAY BE REQUIRED TO MEET FEDERAL REQUIREMENTS.

Employee Signature	Date Signed

FOR MEDICAL and/or DENTAL PREMIUM WAIVERS ONLY

If you DO NOT wish to have your Medical and Dental Premiums taken on a pre-tax basis, you must complete this waiver section.

I hereby waive participation in the automatic premium conversion of State Group Medical and Dental Premiums. I understand that this waiver will remain in effect for the 2011 Plan Year, unless otherwise provided by law. I understand that by waiving the Automatic Premium Conversion, my Social Security and federal income tax liability will not be reduced, and that my premium deductions will be paid with taxable income. ☐ Medical ☐ Dental

Employee Signature ______________________ Date Signed ______________

PLEASE MAKE A COPY FOR YOUR RECORDS.