

Please use this section to indicate any changes you wish to make to your plan for the upcoming year.

Group Information	
Group Name: _____	Further Group Number: _____

Medical FSA			
Plan Effective Date	Start Date ____-____-____	End Date ____-____-____	
Minimum / Maximum Contribution Limits	Minimum \$ _____	Maximum \$ _____ <i>_(IRS Maximum is \$3,200)</i>	
	Does the employer contribute to any account? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p><i>Note: According to IRS FSA regulations, employers can contribute up to \$500 to each employee without contributions from the employee. If the employer contributes more than \$500, the employee must contribute. The employer contribution cannot exceed the amount contributed by the employee.</i></p>			
Grace Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grace Period End Date	____-____-____
Runout Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runout Period Length	_____ months
Account Rollover	<input type="checkbox"/> Yes <i>Balance up to \$640 rolls over to subsequent plan year</i> <input type="checkbox"/> No <i>No balance rolls over</i>		
Reimbursement Options	Please contact Further directly to adjust Crossover or Debit Card elections.		

Dependent Care FSA			
Plan Effective Date	Start Date ____-____-____	End Date ____-____-____	
Minimum / Maximum Contribution Limits	Minimum \$ _____	Maximum \$ _____ <i>(IRS Maximum is \$5,000)</i>	
	Does the employer contribute to any account? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Grace Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grace Period End Date	____-____-____
Runout Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runout Period Length	_____ months

Health Savings Account			
Plan Effective Date	Start Date ____-____-____	End Date ____-____-____	
HSA Plan Type Option	Further Premium HSA <input type="checkbox"/>	Further Select HSA <input type="checkbox"/>	Further Value HSA <input type="checkbox"/>
Participant Fees	Employer Paid <input type="checkbox"/>	Employee Paid <input type="checkbox"/>	
Reimbursement Options	Please contact Further directly to adjust Crossover or Debit Card elections.		

Health Reimbursement Account		
Plan Effective Date	Start Date ____-____-____	End Date ____-____-____
HRA Plan Type Option	<input type="checkbox"/> ER Pays First	Annual Funding Amounts \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family
	<input type="checkbox"/> Shared Payment Reimbursement Level <input type="checkbox"/> 80% of eligible charges <input type="checkbox"/> 50% of eligible charges <input type="checkbox"/> Other _____	Annual Funding Amounts \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family
	<input type="checkbox"/> EE Pays First	Annual Employer Funding Amounts \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family Employee Responsibility Amounts \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family

Health Reimbursement Account (continued)

Mid-Year Enrollees / Contract Changes	<input type="checkbox"/> 100% Funding regardless date of enrollment. <input type="checkbox"/> Funding is prorated in monthly increments back to first of the month of enrollment		
Account Balance Cap	Balance Cap Limit: \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family		
Runout Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runout Period Length	_____ months
Account Rollover	<input type="checkbox"/> Full Rollover		
	<input type="checkbox"/> Flat Dollar Limit	Rollover Limit: \$ _____ Employee \$ _____ Employee & Child \$ _____ Employee & Spouse \$ _____ Employee & Children \$ _____ Family	
	<input type="checkbox"/> Percentage Rollover	_____ %	
	<input type="checkbox"/> No Rollover		
Reimbursement Options	Please contact Further directly to adjust Crossover or Debit Card elections.		

Signature	
Signature: _____	Date: _____

Questions? Call Group Leader Services at 1-888-460-4013

Send via secured email only:
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