



# Flexible Spending Account Enrollment Form

LONG Building Technologies, Inc.

Employer*	Plan Year		
Employee Name*	Social Security Number *		
Employee Street Address	City	State	Zip
Email Address*	Phone	Date of Birth*	

\* Required field

**ELECTION**

<b>Health Care Flexible Spending Account</b>	\$ _____ Contribution per pay period	X	_____ # of pay periods	= \$ _____ your annual election <small>(Cannot exceed \$2,400 per plan year)</small>
<b>Dependent Care Flexible Spending Account</b>	\$ _____ Contribution per pay period	X	_____ # of pay periods	= \$ _____ your annual election <small>(Cannot exceed \$5,000 per household)</small>

**DEBIT CARD**

- I understand that I will automatically receive a debit card with my enrollment in the FSA plan. (If you choose not to use the debit card, shred or otherwise destroy the debit card).
- Yes, I would like to order a card for my spouse or dependent (print name below).

Spouse or Dependent Name	SSN	Birth Date
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**OTHER TERMS AND CONDITIONS**

- I understand that:
- An election is made before a year begins and cannot be changed until the next year. No changes are allowed during the year unless there is a change of status. Change in status events include a change in: legal marital status, number of dependents, employment status, a dependent satisfies or ceases to satisfy eligibility requirements and residence. Changes of status must meet the "consistency" requirement.
  - I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand, for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax on any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
  - The Plan Administrator may reduce my compensation reduction or otherwise modify this agreement in the event it is believed to be advisable in order to satisfy provisions of the Internal Revenue Code.
  - My Social Security benefits may be slightly reduced as a result of my election.
  - This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Company.
  - If my employment is terminated I agree to contact Rocky Mountain Reserve regarding my account.

Employee Signature	Date
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## Health Care Expense Worksheet

\*Not required, for employee use in estimating expenses

### Common Medical Expenses

#### Medical Expenses:

Co pays \_\_\_\_\_  
Deductible \_\_\_\_\_  
Chiropractor \_\_\_\_\_  
Prescriptions \_\_\_\_\_  
Other \_\_\_\_\_

### Estimated Plan Year Total

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Dental Expenses

Cleanings \_\_\_\_\_  
Fillings \_\_\_\_\_  
Crowns \_\_\_\_\_  
Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Vision Expenses

Glasses \_\_\_\_\_  
Contacts \_\_\_\_\_  
Exams \_\_\_\_\_  
Lasik \_\_\_\_\_  
Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Over-The-Counter Expenses

Pain reliever \_\_\_\_\_  
Contact lens solution \_\_\_\_\_  
Band Aids \_\_\_\_\_  
Other \_\_\_\_\_  
(Vitamins and Supplements only with RX)

\_\_\_\_\_  
\_\_\_\_\_

TOTAL:

\_\_\_\_\_

\*All eligible out-of-pocket medical expenses for you, your spouse and your dependents can be reimbursed regardless of insurance coverage.

## Dependent Care Account

\*A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you.

\*The care must be necessary for you or your spouse to be gainfully employed or to go to school.

\*Care may be provided by anyone other than your spouse or your children under the age of 19.

\*Expenses for schooling, kindergarten and above, overnight camp and nursing homes are not reimbursable.

\*The maximum you can elect, in a calendar year, is equal to the smallest of the following:

- \$5,000 – Married and filing federal taxes jointly or a single parent
- \$2,500 – Married and filing separate federal tax return

\*The amount contributed year-to-date, is available for reimbursement.

All elected "Pre-Tax" amounts are exempt from Federal, State, FICA, and Medicare taxes.

Services must be incurred within the plan year in order to be eligible for reimbursement.

Be conservative in your election! Any amount that is not used during the plan year and grace period (if applicable) will revert back to your employer.