



6251 Greenwood Plaza Blvd., Suite 300  
Greenwood Village, CO 80111-4913  
Please return to your Human Resource  
Department for processing

**FLEXIBLE SPENDING ENROLLMENT FORM**  
**COMPLETE AND RETURN TO YOUR EMPLOYER FOR PROCESSING**  
**City of Casper – 11101140**

Name of Employee \_\_\_\_\_ Employee ID# \_\_\_\_\_  
(Please Print Legibly)  
Employee Address \_\_\_\_\_

IF YOU'RE A NEW PARTICIPANT OR A CHANGE HAS OCCURRED PLEASE INDICATE YOUR EFFECTIVE DATE - \_\_\_\_\_

**\*\*Election effective for the plan year of January 1, 2012 through December 31, 2012 \*\***

**MEDICAL / DEPENDENT (DAYCARE) REIMBURSEMENT PROGRAM**

I elect the following benefit coverage at the costs indicated below: **ALL BLANKS MUST BE COMPLETED.**

▶ Deduct \$ \_\_\_\_\_ X  remaining pay periods = Annual election: \$ \_\_\_\_\_ for the **Medical Reimbursement Program.** (Maximum allowed for the plan year is \$3500.00)

▶ Deduct \$ \_\_\_\_\_ X  remaining pay periods = Annual election: \$ \_\_\_\_\_ for the **Dependent Care Reimbursement** (Maximum allowed \$5000 per year or \$2500 per year if married filing taxes separately)

I authorize my gross salary to be reduced by the total indicated above. I understand that it is my responsibility to keep documented records in order to verify reimbursements I might receive. I also understand that if I should fail to use the above flexible spending account funds within the plan year, those funds will be forfeited. This election is **effective on \_\_\_\_\_ for pay date \_\_\_\_\_** and will continue through the end of the plan year, or until this agreement is amended or terminated. I understand that this election can only be changed in the event of a change in family status listed on the change of status form. **I understand that I have 90 days from the end of my plan year OR 90 days from my termination date to submit my claims that were incurred during my time of eligibility.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

▶ **Auto reimbursement feature: If you or ANY of your dependents are enrolled in a different health plan other than CNIC Health Solutions, you are NOT eligible for this feature. Sign below only if interested AND eligible.**

I authorize CNIC Health Solutions to automatically deduct from my Flexible Spending Account, eligible items that are not reimbursed after my medical claims have been processed. I understand that in order to be reimbursed, I must have sufficient pledge amount for the year to cover the submitted expenses. **I also understand that once the plan year has begun, the auto-reimbursement feature must remain in effect for the duration of the plan year. I understand it is my responsibility to notify CNIC Health Solutions if my eligibility to participate in this feature changes due obtaining other insurance that is secondary to my Medical plan.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_

▶ **Direct Deposit Feature** Please check one box:

- I elected the Direct Deposit feature for the 2010 plan year and would like to retain the same banking information.
- I elected the Direct Deposit feature for the 2010 plan year and would like to discontinue this benefit for the 2011 Plan Year.
- I did not elect the Direct Deposit feature for the 2010 plan year and would like to enroll for the 2011 Plan year. Please complete and sign the separate banking form, attach a voided check and return to your employer.
- I did not want to participate in this feature.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

I am aware that my employer offers the "Grace Period" benefit. Expenses that I submit that are incurred during this grace period will be processed on a first in-first out-basis and applied to the applicable plan year. Adjustments will not be made after the claims are processed.

# WHAT TAX SAVINGS WOULD I GAIN BY PARTICIPATING IN THE PLAN?

SAMPLE USING SEMI-MONTHLY PAYROLL:

	BEFORE Flex	AFTER Flex
Gross Compensation	\$1200.00	\$1200.00
Less Pre-tax benefits:		
Medical Insurance Premium		\$ 100.00
Medical Reimbursement Program*		\$ 25.00
Dependant Care Reimbursement**		\$ 200.00
Gross Taxable Pay	\$1200.00	\$ 875.00
Less Taxes and other Deductions		
Federal Income Tax	\$ 150.00	\$ 109.00
State Income Tax	\$ 60.00	\$ 44.00
Social Security Tax	\$ 92.00	\$ 67.00
Less After-tax expenses		
Medical Insurance	\$ 100.00	
Medical Care Expenses	\$ 25.00	
Dependent Care Expenses	\$ 200.00	
Net Spending Income	\$ 573.00	\$ 655.00
<b>SAVINGS PER PAY CHECK</b>		<b>\$ 82.00</b>
<b>SAVINGS PER YEAR</b>		<b>\$1968.00</b>

**\*WHAT ARE YOUR YEARLY MEDICAL CARE EXPENSES?**

**MEDICAL:**

\$ Health Insurance Deductible \_\_\_\_\_  
 \$ Co-insurance (usually 20%) \_\_\_\_\_  
 \$ Co-payments \_\_\_\_\_  
 \$ Routine Physical Exams \_\_\_\_\_

**VISION:**

\$ Vision Insurance Deductible \_\_\_\_\_  
 \$ Co-Insurance \_\_\_\_\_  
 \$ Eye Exams Contacts, Glasses \_\_\_\_\_  
 \$ Contacts, Glasses \_\_\_\_\_  
 \$ Lasik (each eye) \_\_\_\_\_

**DENTAL:**

\$ Dental Insurance Deductible \_\_\_\_\_  
 \$ Co insurance \_\_\_\_\_  
 \$ Major Restorative @ 50% \_\_\_\_\_  
 \$ Over yearly plan maximum \_\_\_\_\_  
 \$ Braces and Retainers \_\_\_\_\_

**TOTAL EXPENSES \$ \_\_\_\_\_**

**\*\*HOW MUCH DO YOU SPEND ON DEPENDENT CARE?**

*Keep in mind; you could have more or less in expenses during the summer, or for vacations.*

IRS allows a maximum amount of \$5000.00 yearly per family or \$2500.00 yearly if married and filing single.

\$ Child Care weekly amount: \_\_\_\_\_  
 Yearly amount: \_\_\_\_\_  
 \$ Summer Camp \_\_\_\_\_  
 \$ Before and After School \_\_\_\_\_  
 \$ Au Pair expenses \_\_\_\_\_

