STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS PLAN ENROLLMENT FOR ANNUAL ENROLLMENT AND NEWLY ELIGIBLE EMPLOYEES— PLAN YEAR 2025

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

This is NOT an application for insurance. To enroll or change medical or dental insurance you must complete the proper insurance enrollment form. Complete this form only if you wish to participate in the Medical, Limited Purpose or Dependent Care Reimbursement Account

EMPLOYEE INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
HOME ADDRESS	CITY	STATE	ZIP CODE
DEPARTMENT NAME	DEPT ID / BUDGET CODE	DATE HIRED	EMPLOYEE ID
WORK PHONE	PAYROLL FREQUENCY (PAYCHECKS PER YEAR) ❑ 12 ❑ 24 ❑ Other ______	ENROLLMENT STATUS ❑ New Hire ❑ Revision	

REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your HR office for additional information or you may call Benefits Administration at 615.741.3590 or 800.253.9981.

If you are enrolled in the CDHP/HSA, you are not eligible to contribute to the Medical Expense Account; however, you may contribute to the Limited Purpose Account (for vision and/or dental expenses only).

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

MEDICAL EXPENSE ACCOUNT	LIMITED PURPOSE ACCOUNT	DEPENDENT CARE ACCOUNT
Maximum allowable annual contribution is $3,200	Maximum allowable annual contribution is $3,200	**Tax Filing Status (please check one)** ❑ Married, filing separately (maximum $2,500) ❑ Married, filing jointly (maximum $5,000) ❑ Head of household (maximum $5,000)
Box #1 Reduction per regular paycheck	Box #1 Reduction per regular paycheck	Box #1 Reduction per regular paycheck
Box #2 Number of regular paychecks expected X	Box #2 Number of regular paychecks expected X	Box #2 Number of regular paychecks expected X
Box #3 Total plan year dollar amount =	Box #3 Total plan year dollar amount =	Box #3 Total plan year dollar amount =

See page 2 to complete and sign this Flexible Benefits enrollment form.

AUTHORIZATION

- I confirm that the information above is true.
- I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.
- 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 that the amount of salary reduction will include the items specified above and will continue in effect for the current plan year (to include termination of employment) unless I file an approved request for a mid-year change due to a status change event.
- I understand that any amount remaining in my Dependent Care FSA that is not used during the plan year will be forfeited since it cannot be carried to the next plan year. I also understand that any funds in excess of $640 remaining in either the General Medical FSA or Limited Purpose FSA at the end of the year will be forfeited. Funds of $640 or less will carry over into the following year if I re-enroll.
- I understand and agree that the state will not incur any liability resulting from either my participation in a flexible benefit or from my failure to 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 forego my right to participate during the upcoming plan year.
- I understand that if I terminate employment during the plan year, I have 90 days from my termination date to submit claims for eligible expenses and that any claims submitted for reimbursement must be for dates of service on or prior to my termination date. Any funds left in my account(s) after the 90 days are forfeited.
- I acknowledge that FSA funds may only be spent on certain expenses. Medical Flexible Spending Account (FSA) and Limited Flexible Spending Account (L-FSA) debit card holders may be required to provide proof that expenses paid for with their debit card are covered expenses permitted by federal law and the FSA program. This is called "substantiation." The State's authorized contractor may send requests for substantiation to plan members.
- When a debit card expense is not substantiated, employers are required to recover the unsubstantiated expense through a number of mechanisms, including payroll deduction. FSA and L-FSA debit card holders must consent to payroll deductions from their wages to repay unsubstantiated expenses. Anyone who refuses to consent to these terms will not be allowed to enroll in the FSA or L-FSA.
- If I enroll in a Health FSA, I hereby agree that the State may deduct from my pay the amount of any expenses that remain unsubstantiated at the end of the runout period to the extent permitted by applicable law. This authorization of payroll deduction is a condition to participate in an FSA or L-FSA.

EMPLOYEE SIGNATURE	DATE

Return this application to your human resource office after making a copy for your records.
For questions regarding enrollment or a status change event, please call Benefits Administration at 615.741.3590 or 800.253.9981.
For questions regarding reimbursement requests, please call Optum Bank at 866.600.4984.