BASIC
www.basiconline.com
800.444.1922

# BASIC LIMITED PURPOSE FLEX

## *do you have an HSA?*

BASIC Limited Purpose Flex is a reimbursement account specifically designed for individuals with a Health Savings Account (HSA). IRS regulations state that an individual with an HSA may not simultaneously have a general purpose flex plan, but they are allowed a limited purpose flex plan. If you or your spouse are currently enrolled or plan to enroll in an HSA during your flex plan year, a limited purpose flex plan might be just what you need. The difference between BASIC Flex and BASIC Limited Purpose Flex is the eligible expenses. A BASIC Limited Purpose Flex plan only allows for reimbursements of dental, vision and post deductible expenses (co-insurance and co-pay expenses after your deductible has been met). With a limited purpose flex, you may still sign up for a dependent care account.

With BASIC Limited Purpose Flex, you elect to have a certain dollar amount transferred from your paycheck into a special account to pay for dental and vision expenses as they occur. This money is taken from your gross pay prior to taxes. You save by not having to pay federal and most state and local taxes, as well as Social Security and Medicare taxes, on the amount you set aside.

## ELIGIBLE **EXPENSES.**

| DENTAL | VISION | POST DEDUCTIBLE |
|---|---|---|
| Orthodontic | Glasses | Co-insurance after the deductible has been met |
| Dentures/bridge/crowns | Eye exam | |
| Fluoride treatments & seals | Contact lenses | Co-payments after the deductible has been met |
| Cleanings and fillings | Contact lens solution | |
| Root canals | Prescription sunglasses | |
| Extractions | LASIK surgery | |

IRS regulations govern the eligibility of claims which include those that are not fully covered by a health care plan and are prescribed by a physician or other licensed professional, primarily for preventing, treating or mitigating a physical defect or illness. The IRS does not allow reimbursement for the following: cosmetic surgery, insurance premiums, teeth bleaching / whitening, health club fees, nutritional supplements/vitamins, marriage counseling, eyeglass sun clips and prepayment of services. For more details, refer to IRS Publication No. 502.

# BASIC LIMITED PURPOSE FLEX

PLEASE PRINT AND WRITE CLEARLY. INFORMATION BELOW IS USED TO ENSURE ACCURATE ENROLLMENT.

Employer Name: _____

Participant Name: _____ Last 4 digits of SS #: ___ ___ ___ ___

Address: _____ Date of Birth: _____/_____/_____

City, State, Zip: _____ Phone Number: _____

E-mail Address: _____ (Notification of direct deposit payment is sent via e-mail)

Pay Period: ☐ Weekly ☐ Semi-Monthly (twice a month) ☐ Bi-Weekly (every other week) ☐ Monthly

## PREMIUM CONTRIBUTIONS

☐ I elect to participate
The amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer.

**EMPLOYER USE**
Employer must complete for mid-year enrollments
Date of first deduction:
_____
Eligibility date:
_____

## DEPENDENT CARE ACCOUNT

☐ I elect to participate
(not to exceed $5000 or $2500 if married filing separately)

$ _____ Annually

## LIMITED PURPOSE REIMBURSEMENT ACCOUNT

☐ I elect to participate
(not to exceed employer limit of $_____)

$ _____ Annually

## DIRECT DEPOSIT

☐ I elect to participate (please do not fill out if you are already participating, unless you are changing accounts)
☐ checking account OR ☐ savings account


Financial Institution (name of bank): _____

Routing Number (always 9 digits): _____

Account Number: _____
If you would prefer, you can attach a voided check

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by the sum of my limited purpose medical reimbursement, dependent care and premium contributions to the plan, with such amount to be allocated among the benefits I selected above. I understand I am enrolling in a "limited purpose" flex plan and that this means I have planned my election to cover my predictable out-of-pocket dental and vision expenses. I understand this election form cannot be revoked or changed during the plan year unless there is a qualified change in status as defined in the Summary Plan Description (SPD). I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars remaining in my account(s) at the end of the plan year will be forfeited. I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

Employee Signature _____ Date _____