



Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Worksm



Unreimbursed Medical/Dependent Care FSA Election Form

(See worksheet on back to assist you in determining your election for next year.)

Please return this form to your employer.

S.S. # | _ | _ | _ | - | _ | _ | - | _ | _ | _ | _ |

Employee Name (print) _____

Home Address _____

City _____ State _____ Zip Code _____

E-mail address _____

Home Phone #: () _____ Work Phone #: () _____

Date of Hire: _____ Date of Birth: _____

Employer Name: _____

Unreimbursed Medical

I elect to participate in the Unreimbursed Medical Flexible Spending Account. I direct and authorize my employer to reduce my annual salary for the plan year _____ by \$ _____. I understand that my salary will be reduced in **equal amounts** from my regular paycheck.

I elect **not** to participate at this time.

Dependent Care

The total amount I can deposit into my Dependent Care Flexible Spending Account cannot exceed the lesser of \$5,000 (\$2,500 for a married person filing separately) or my spouse's earned income. **If my spouse does not work and is not disabled or a full-time student, I cannot participate in the Dependent Care Spending Account.**

I elect to participate in the Dependent Care Flexible Spending Account. I direct and authorize my employer to reduce my annual salary for the plan year _____ by \$ _____ (maximum \$5,000 – see above). I understand that my salary will be reduced in **equal amounts** from my regular paycheck.

I elect **not** to participate at this time.

I understand the following: This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g. legal separation, divorce, or marriage; birth or legal adoption of a child; death of a dependent; change in work status for you or your spouse; or change in cost or coverage for Dependent Care).

I can continue to file claims for expenses incurred during the plan year until three months following the end of the plan year. Funds not used during the plan year are forfeited. In effect, I must “use it or lose it.”

YOUR SIGNATURE _____ DATE _____

Plan Enhancements

Interactive Web site

Horizon Blue Cross Blue Shield of New Jersey Web site can be reached at www.HorizonBlue.com/fsa.

- **Online Worksheets**
 - Dependent Care vs. Federal Tax Credit.
 - Unreimbursed Medical Worksheet.
- **Online Claim Entry Module**
 - Submit your Unreimbursed Medical and Dependent Care claims over the Internet (Available now!).
- **Downloadable Forms**
 - Download and print Flexible Spending Account forms directly to your PC: FSA Election Form, Direct Deposit Enrollment, Change in Status and more
- **Online Account Balance Inquiry**
 - Receive up-to-date account balance information over the Internet.
- **Online Claim List**
 - Provides information on the most recent claims submitted.
- **Online Payment List**
 - Details the most recent FSA payments issued from your account(s).
- **Direct Deposit**
 - Participants will be able to elect direct deposit of FSA reimbursements into a checking or savings account.

Worksheet

Unreimbursed Medical FSA	Prior Year Actual Expenses	Projected Expenses
List the amount you spent for:		
Deductibles/coinsurance	\$ _____	\$ _____
Vision care/LASIK eye surgery (eye exams, contact lenses solutions and eyeglasses)	\$ _____	\$ _____
Routine exams if not covered by insurance (Ob/Gyn, well visits, etc.)	\$ _____	\$ _____
Prescription drugs (including birth control) (Does not include cosmetic prescriptions)	\$ _____	\$ _____
Certain over-the-counter drugs*	\$ _____	\$ _____
Travel costs related to medical care	\$ _____	\$ _____
Other	\$ _____	\$ _____
List the amount you spent for out-of-pocket dental expenses:		
Examinations and cleanings	\$ _____	\$ _____
Fillings, crowns and bridges	\$ _____	\$ _____
Orthodontics/periodontics	\$ _____	\$ _____
Dentures/implants/X-rays	\$ _____	\$ _____
Total	\$ _____	Total \$ _____
Projected Unreimbursed Medical FSA Deposit	\$ _____	
Dependent Care FSA	Prior Year Actual Expenses	Projected Expenses
Payments made for dependent care services provided in your home	\$ _____	\$ _____
Day care center/nursery school	\$ _____	\$ _____
Before- or after-school care/summer day camp facility	\$ _____	\$ _____
Total	\$ _____	Total \$ _____
Projected Dependent Care FSA Deposit	\$ _____	

* Visit our Web site at www.HorizonBlue.com/fsa to download a detailed listing of eligible over-the-counter items.