FBMC

Premier Benefits Solutions

P.O. Box 1878 Tallahassee, FL 32302-1878

Plan Year 2010

SOUTH CAROLINA BUDGET & CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM MONEYPLU$ ENROLLMENT FORM

You must complete this form if you wish to start a tax-free Medical Spending and/or Dependent Care Spending Account or to enroll in or change a Health Savings Account.

Please be sure to read the* IMPORTANT *information on the back of this form.
Submit your completed form to your Benefits Administrator.
Please press hard with a black ballpoint pen.

Name (Please Print) Last	First	MI	Social Security #	
Mailing Address Street (HSA participants cannot list a P.O. Box.)	City	State	ZIP Code	Date of Birth / /
Physical Address Street	City	State	ZIP Code	Annual Salary $

Daytime Phone ( )	Home Phone ( )	Date of Hire / /	E-mail Address

Complete **Section A** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA. Refer to your ***Tax-Favored Accounts Guide*** for more information.) If you would also like to enroll in a **limited-use Medical Spending Account** for eligible dental and vision expenses, complete **Section B**. To enroll in a **Medical Spending Account**, complete **Section C**. To enroll in a **Dependent Care Spending Account**, complete **Section D**. In **Box #1**, indicate the dollar amount you elect to contribute for the upcoming plan year. In **Box #2**, indicate the number of regular payroll checks you will receive during the upcoming plan year. In **Box #3**, indicate the reduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.)

A Health Savings Account (Additional forms are required.)

☐ NEW ACCOUNT ☐ CONTRIBUTION AMOUNT CHANGE

Select which type of SHP Savings Plan coverage you have:

☐ Individual ($3,050 maximum in 2010) ☐ Family ($6,150 maximum in 2010)
☐ Over 55 Catch-up (additional maximum $1,000)

		EMPLOYEE	FOR BA USE ONLY: EMPLOYER
Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010)			
Box #2 Pay Period Election	÷		
Box #3 Reduction Per Regular Paycheck	=		

NBSC will deduct a $1 monthly administrative fee from your HSA.
FBMC will deduct a $1 monthly administrative fee from your paycheck.

B Limited-use Medical Spending Account

☐ NEW ENROLLMENT ☐ RE-ENROLLMENT (Available to HSA Participants only)

Receive reimbursement for eligible dental and vision expenses incurred by you, your family members or both. [Maximum allowable contribution is $5,000 annually.]

Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010)		
Box #2 Number of Regular Paychecks	÷	
Box #3 Reduction Per Regular Paycheck	=	

Your payroll center will automatically deduct the monthly fee of $3.50 in addition to the above amounts.

IF YOU ENROLL IN A HEALTH SAVINGS ACCOUNT (SECTION A), YOU CANNOT ENROLL IN A MEDICAL SPENDING ACCOUNT (SECTION C), BUT MAY ENROLL IN A LIMITED-USE MEDICAL SPENDING ACCOUNT (SECTION B).

C Medical Spending Account

☐ NEW ENROLLMENT ☐ RE-ENROLLMENT

Receive reimbursement for eligible medical expenses incurred by you, your family members or both. [Maximum allowable contribution is $5,000 annually.]

Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010)		
Box #2 Number of Regular Paychecks	÷	
Box #3 Reduction Per Regular Paycheck	=	

Your payroll center will automatically deduct the monthly fee ($3.50) in addition to the above amounts.

DO YOU WISH TO PARTICIPATE IN THE myFBMC Card[SM] PROGRAM? ☐ **YES** ☐ **NO**
If you select the card, your Medical Spending Account will be assessed a $10 per-plan-year fee.
Note: You must select "**YES**" above if you wish to continue using your myFBMC Card[SM].

D Dependent Care Account

☐ NEW ENROLLMENT ☐ RE-ENROLLMENT

Tax filing status, please check one:

☐ Married, filing separately (Maximum - $2,500) ☐ Single, head of household (Maximum - $5,000) ☐ Married, filing jointly (Maximum - $5,000)

Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010)		
Box #2 Number of Regular Paychecks	÷	
Box #3 Reduction Per Regular Paycheck	=	

Your payroll center will automatically deduct the monthly fee ($3.50) in addition to the above amounts.

☐ I plan to retire or terminate my employment prior to December 31, 2010. I wish to have my full amount (in Box #1 of any and all accounts) withheld from my first _______ paychecks (this number should be less than Box #2 of any and all accounts).

Please read reverse side before signing this form below.

EMPLOYEE SIGNATURE:	**DATE:**

FOR BA USE ONLY:

For MONEYPLU$ eligibility purposes, I certify that this employee is eligible for the Account(s) in which the employee is enrolling. If the employee has enrolled in an HSA, I certify that the employee is also enrolled in the State Health Plan Savings Plan, and, if applicable, has correctly accounted for the Employer Contribution.

EMPLOYER/BENEFITS ADMINISTRATOR SIGNATURE: ______________________ **DATE:** __________

Effective Date ____________ Payroll Date ____________ Payroll Center ______________ Payroll Frequency ________ Group Number ____________

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED

BENEFITS ADMINISTRATORS: Send signed form to: Enrollment Processing, P.O. Box 1878 Tallahassee, FL 32302-1878

 FBMC COPY: WHITE EMPLOYER/BENEFITS ADMINISTRATOR COPY: YELLOW EMPLOYEE COPY: PINK