

MEDICAL CARE ASSISTANCE PLAN

ENROLLMENT FORM **FY**____

| Section A – Type of Enrollment | | | | | | | |
|---|--|-----------|--------|-------------------------------|-------------------|--|--|
| □ Ве | nefits Choice Enrol | llment | | | | | |
| ☐ Ne | | Date of | Hire / | / | | | |
| ☐ Mid | d-Year Enrollment | | | | art in Section D) | | |
| I certify that the above eligible change in status event occurred on // | | | | | | | |
| Section B – Employee Information | | | | | | | |
| Social Secu | urity Number | Last Name | First | | Initial | | |
| Street Add | ress | City | State | Zip Code | Home Phone | | |
| | | | | | () | | |
| Agency | | | | | Work Phone | | |
| Section C – Deduction Information, Authorization and EZ REIMBURSE® MasterCard® Request Deduction Information and Authorization - I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my MCAP account. | | | | | | | |
| The number of deductions for semi-monthly or bi-weekly payrolls is 24. The number of deductions for monthly payrolls is 12 (university employees could have less than 12). | | | | | | | |
| \$ Deductio | Deduction Amt Per Pay X Number of Deductions Total Annual MCAP Expenses * (Minimum = \$240.00; Maximum = \$5,000.00) | | | xpenses * um = \$5,000.00) | | | |
| * If you elect to receive the EZ REIMBURSE® MasterCard® (below), you must include the non-refundable \$20.00 card fee in your annual deduction calculation. To figure the amount that will be deducted each pay period, divide the annual deduction amount by the number of deductions in the plan year. The total annual MCAP deduction amount cannot be greater than \$5,000.00. The amount eligible for reimbursement is the total annual deduction amount less the \$20.00 fee. | | | | | | | |
| | URSE Card | | | | | | |
| Yes! I want the EZ REIMBURSE® MasterCard®. I understand that even if I had the card during a previous plan year, I must REQUEST the card for the plan year in which I am enrolling. I understand there is an annual non-refundable \$20.00 fee which will be automatically deducted from my MCAP account. I agree to submit proper documentation for all EZ card transactions that are not a known co-payment amount, as required by the IRS. | | | | | | | |

Section D - Change in Status Code Chart

| 01 | Birth or adoption of dependent |
|----|---|
| 02 | Marriage |
| 03 | Divorce, legal separation or annulment * |
| 07 | Change of county of residence/worksite for employee or spouse * |
| 08 | Judgment, decree or court order * |
| 10 | Employee commences employment |

| 11 | Employee returns to payroll (from being on a leave of absence) |
|----|--|
| 13 | Employee changes employment status from Part-time less than 50% to Full-time |
| 15 | Spouse or dependent terminates employment |
| 17 | Spouse or dependent changes employment status from Full-time to Part-time |
| 20 | Spouse enters leave of absence and loses FSA enrollment |
| 24 | Coordination of spouse's annual benefit election period |

Section E - Certification Statement (Please read carefully before signing)

I understand and certify that:

- I may not change or stop my account deposits during the plan year unless I experience a qualifying change in status.
- I will forfeit any unclaimed amount remaining in my account at the end of the run-out period. The run-out period ends September 30th following the last day of the plan year.
- I understand that deductions must continue during any paid leave of absence.
- I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.
- I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed, up to and including filing an order of involuntary withholding through the Office of the Comptroller.
- I understand that due to the IRS Grace Period, I can submit claims and use my EZ REIMBURSE® MasterCard® for eligible services incurred from the end of the plan year through September 15th and that those charges will be deducted from the prior plan year's account balance, if any. Expenses incurred during the Grace Period that exceed the previous year's account balance, as well as expenses incurred after September 15th, will be reimbursed out of that plan year's account, if enrolled.
- If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a check was issued, unless I elect to continue my participation through direct payments to the FSA Unit.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.

| Employee Signature: | Date / / | | | | | |
|---|---------------------------|--|--|--|--|--|
| Please return the signed, completed form to your agency Group Insurance Representative. | | | | | | |
| | | | | | | |
| | | | | | | |
| Section F – Agency Approval (To be completed by Group Insurance Representative) | | | | | | |
| Effective Date: / | Deduction Start Date: / / | | | | | |
| If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction: | | | | | | |
| | / | | | | | |
| Organizational Processing Code: | Pay Code: | | | | | |
| GIR Signature: | Date: / | | | | | |
| Telephone () | | | | | | |
| GIR Instructions: Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefits Choice Enrollment; or option 2, | | | | | | |

- Use the FSA Inquiry Screen option 1, Deduction What If Screen Benefits Choice Enrollment; or option 2,
 Deduction What If Screen Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start
 Date. If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected
 deduction.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

^{*} Reviewed case-by-case