Enrollment Form

EMPLOYER CLARK ATLANTA UNIVERSITY **PLAN EFFECTIVE DATE** JANUARY 1, 2021

☐ **ANNUAL ENROLLMENT** ☐ **NEW HIRE** ☐ **CHANGE IN STATUS** **EMPLOYER SIGNATURE REQUIRED**

EMPLOYEE
Last First MI Social Security #

Date of Birth Effective Date Hire Date Gender

PAY CYCLE
☐ BIWK ☐ MTHLY
☐ SEMI ☐ WKLY

MAILING ADDRESS
Street City State Zip

EMPLOYEE'S EMAIL ADDRESS (By providing my email address, I understand that all correspondence will be sent to me via email)

PHONE NUMBER

COMPLETE DEPENDENT INFORMATION FOR 2ND CARD.
First Name Last Name Social Security # Date of Birth

I elect to participate in the following:	MAXIMUM	ANNUAL ELECTION	PER PAY PERIOD		Check below if applicable
HEALTH FSA (Medical/Dental/Vision/RX/OTC)	**$2,750**	$	$	☐	I elect **NOT** to participate
DCA (Dependent Day Care)*	**$5,000**	$	$	☐	I elect **NOT** to participate
		$	$	☐	I elect **NOT** to participate
		$	$	☐	I elect **NOT** to participate
		$	$	☐	I elect **NOT** to participate

Sign up for direct deposit for manual claim reimbursements!

Financial Institution/Bank Name	**Financial Institution's Address**
Checking Account ☐ **Savings Account** ☐	**Financial Institution's City, State, Zip**
Account Number	**Name as it appears on the Account**
Transit Routing Number/ABA	

You must attach either: a voided check (for checking account), **OR** a voided savings deposit slip (for savings account only). Your request will not be processed without this information.

Consumer Driven Health Plans

Contact us:
(800) 523-7542
www.medcombenefits.com
medcomreceipts@medcombenefits.com

PARTICIPATION AUTHORIZATION OR WAIVER OF COVERAGE

I hereby authorize my employer to take pre-tax payroll deductions per pay period from my pay in the amount(s) I have elected above, or I certify that I am electing to participate in my Employer's HRA Plan and understand the terms of the Plan. I understand that I cannot change or revoke the above amounts except during the Plan's Annual Open Enrollment Period unless I have a qualifying family status change and my Plan allows for such changes. Further, if I am a recipient of the Debit Card, I hereby certify that I understand the following guidelines: 1) the Card may only be used for eligible expenses obtained at qualified, health care related merchants; and, 2) that any expense paid for with the Card is not eligible for reimbursement by any other source and I certify that I will not seek reimbursement under any other plan covering health benefits; and, 3) I must obtain and retain sufficient documentation for any expense paid with the Card and provide upon request; and, 4) I further certify that I understand that I must immediately repay ineligible reimbursements. If I have a Card, it will be deactivated until the full amount of any ineligible expenses is repaid; and, future claims may be offset; or, at my employer's discretion, ineligible expenses may be payroll deducted from my paycheck.

I further authorize the Claims Administrator to release and/or obtain any medical or benefits coverage information pertaining to myself (or to my eligible dependent(s) that may have health plan coverage) that may be necessary to facilitate payment of benefits under the HRA plan.

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions obtain, verify and record information that identifies each person who opens an account. What this means to you: when you open an account we will need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.

Further, the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me). I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding. I am a U.S. citizen or other U.S. person. This Authorization is being provided in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations insured there under. This Authorization shall remain in effect for as long as I am enrolled in coverage with a Medcom issued health insurance plan connected with the above- referenced HSA.

Employee Signature ______________________________ **Date** ______________

WAIVER OF COVERAGE

By signing below, I hereby elect **not to participate** in the benefit plans listed above offered to me by my Employer. I certify that I further understand that if I have waived enrollment in any of the above plans: **(1)** I will not have another opportunity to enroll until the next open enrollment period and **(2)** if I waive or decline enrollment in the Premium Conversion Plan (but am participating in any of the group health plans), the premiums I pay will be deducted on an after tax basis.

Employee Signature **Date**

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