# Kentucky Community & Technical College System
# 2011 Enrollment Form

CHARD SNYDER

You will be making elections for the **January 1, 2011** through **December 31, 2011** Plan Year. After completing this form, please sign, date, and **return it to your HR Director on or before October 24, 2010.**

If you have any questions, please contact your human resource representative or contact Chard Snyder at (513) 459-9997, Toll free (800) 982-7715, or visit our website at www.chard-snyder.com.

| EMPLOYEE INFORMATION | | | |
|---|---|---|---|
| First Name | | Home Phone ( ) - | |
| Last Name | | Work Phone ( ) - | |
| SSN | Email Address | | |
| Street Address | | | Apt# |
| City | | State | ZIP |
| Pay Frequency | Semi-Monthly | | _____ |

| PLAN ELECTION DESCRIPTIONS | SELECT ELECTION(S) & AMOUNT(S) | |
|---|---|---|
| **Health Reimbursement Arrangement (HRA)**<br>Reimbursement of expenses as explained in your enrollment materials.<br>**ONLY ELECT THIS BENEFIT IF YOU ARE WAIVING MEDICAL COVERAGE** | ☐ I elect coverage | |
| **Direct Deposit (If selecting this option - ALL Bank Information Below is REQUIRED)**<br>Used for paper claims sent to Chard Snyder for reimbursement directly to your personal bank account.<br>***Note**: In the event that your direct deposit transaction is returned, Chard Snyder reserves the right to collect a $25 processing fee.*<br>Bank **Nine** Digit Routing Number (Include ALL Zeros):<br>___ ___ ___ ___ ___ ___ ___ ___ ___<br>Bank Account Number: _____<br>(Include All Zeros)<br>Bank Name: _____ | Select One Below:<br>☐ Start Direct Deposit<br>☐ Change Account<br>☐ Continue with Account on File<br>☐ Cancel/Stop Direct Deposit | Account Type:<br>Select One Below:<br>☐ Checking<br>☐ Savings |

## EMPLOYEE AUTHORIZATION

I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I have received and read all the authorizations & acknowledgements provided by Chard Snyder for each plan elected above on the second page of this form. I also acknowledge the receipt of the HIPAA Privacy Notice provided at open enrollment and/or provided on the Chard Snyder website (www.chard-snyder.com).

Signature Date / /

## CLIENT USE ONLY (MUST BE COMPLETED BY HR FOR NEW HIRES)

Employee Effective Date / / 1st Contribution Date / / Initials

## EMPLOYEE ACKNOWLEDGEMENT & AUTHORIZATIONS (SEE BELOW)

All sections may not apply. Each section is only applicable if you are electing to participate.

## HRA - ACKNOWLEDGEMENT & AUTHORIZATION:

**I understand that:**

- I am enrolling in a qualified plan and a description of the plan has been made available to me.
- I have 90 days after coverage termination date to submit claims for reimbursement.
- Funds available in the HRA account may be used for eligible expenses deemed permissible under Section 213 of the Internal Revenue Code, provided that my employer has not chosen to limit the HRA to certain items.
- Eligible expenses, including dental, health, and vision expenses and long term care premiums, must be incurred while an eligible participant to be considered for reimbursement (the date of service, not the billing date, must occur while a participant in the Plan).
- Out-of-pocket expenses cannot be itemized and deducted again on an IRS Form 1040 or reimbursed again through any other benefit programs.
- I understand that I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby understand the information on this form and authorize Chard Snyder to complete my request.

## DIRECT DEPOSIT - ACKNOWLEDGEMENT & AUTHORIZATION:

**I understand that:**

- My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
- I permit Chard Snyder to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and / or debit the same to such account.
- Direct deposit of my reimbursements shall commence within 4 weeks of receipt of this form.
- My direct deposit may be terminated per any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, or cancellation of direct deposit by my employer.

I hereby understand the information on this form and authorize Chard Snyder to complete my request.