

MEDICAL CARE ASSISTANCE PLAN ENROLLMENT FORM **FY** _____

Section A – Type of Enrollment

Benefits Choice Enrollment

New Hire Date of Hire _____ / _____ / _____

Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on _____ / _____ / _____

Section B – Employee Information

<i>Social Security Number</i>	<i>Last Name</i>	<i>First</i>	<i>Initial</i>
			()
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
			<i>Home Phone</i>
			()
<i>Agency</i>			<i>Work Phone</i>

Section C – Deduction Information and Authorization

EZ Reimburse Card

Yes! I want the EZ REIMBURSE card. I understand there is an annual fee of \$20.00 per plan year which will be deducted from my MCAP account and that I may only request to receive the EZ REIMBURSE card upon enrolling in MCAP for the first time during the current plan year.

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.

\$ _____	X	_____	=	\$ _____
Deduction Amt Per Pay		Number of Deductions		Total Annual MCAP Expenses *
				(Minimum = \$240.00; Maximum = \$5000.00)

* If you elect to receive the EZ REIMBURSE debit card (above), you must include the \$20.00 card fee in your annual deduction calculation. To figure the amount which will be deducted each pay period, divide the annual deduction amount by the number of deductions remaining in the plan year. The total annual MCAP deduction amount cannot be greater than \$5000.00. The amount eligible for reimbursement is the total annual deduction amount less the \$20.00 fee.

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/worksites 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

* Reviewed case-by-case

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.*
- *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.*
- *I understand that services incurred after my payroll deductions or direct monthly payments (as a result of COBRA) cease, are ineligible for reimbursement.*
- *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 for 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: ____ / ____ / ____

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, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.