Advanced Benefit Strategies
*Your Flexible Benefits Specialists*

# Section 125 & 132

## HCR, DCR, TRN & PRK – Enrollment **(limited HCR included)** IRS Section 125 &132

Health Care (HCR) Dependent Care (DCR) Transit/Commuting (TRN) & Qualified Parking (PRK)

**I. Employee Enrollment**

| | | | | |
|---|---|---|---|---|
| Employer Name: | | | | |
| Your Name (last, first, middle) | Social Security Number | | Date of Birth | Gender / Marital Status |
| Mailing Address | City | State | Zip | ( ) Day Time Phone Number |
| email address: | | | | |

**II. List Dependents** *(If any)*

| | | | |
|---|---|---|---|
| Spouse's name (last, first, middle) | Date of Birth | Dependent's name (last, first, middle) | Date of Birth |
| Dependent's name (last, first, middle) | Date of Birth | Dependent's name (last, first, middle) | Date of Birth |

**III. Enrollment Election** *(check which plans you want and complete information)*

☐ Yes, I elect to participate in a Dependent Care Reimbursement (DCR) Account: Annual Election: $_____
☐ No, I do not elect to participate.

| | |
|---|---|
| Name of Dependent Care Provider: | Tax ID # or SS # |

☐ Yes, I elect to participate in a Health Care Reimbursement (HCR) Account: Annual Election: $_____
☐ Yes, I elect the **LIMITED** Health Care Reimbursement (LMT) due to participation in a HSA: Annual Election: $_____
☐ No, I do not want to participate.

☐ Yes, I elect to participate in a Transit / Commuting (TRN) Account: Monthly Election: $_____
☐ No, I do not want to participate.

☐ Yes, I elect to participate in a Qualified Parking (PRK) Account: Monthly Election: $_____
☐ No, I do not want to participate.

I certify that all the information on this form is correct. I understand that: Any amount remaining in my Health Care Reimbursement (HCR) and/or Dependent Care Reimbursement (DCR), accounts at year end will be forfeited in accordance with current plan provisions and the IRS tax laws; and that all plan deductions are in effect for the full plan year and cannot be changed or stopped unless I experience a change in family or employment status.

Employee's Signature:_____ Date: _____

*Return completed Enrollment Form to your Benefit Department*

| | | | |
|---|---|---|---|
| **Employer Use REQUIRED** | Date of Hire: / / | Effective Date: / / | # of paychecks remaining this Plan Year: |
| Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly | | | Pay Date of First Deduction: / / |
| Health Care Deduction Per Pay Period: $ | Dependent Care Deduction Per Pay Period: $ | Transit/Commuting Per Pay Period: $ | Qualified Parking Per Pay Period: $ |

☐ Mid-Year Status Change (See plan document for list of qualifying events) Explain:

*Note to employer Representative: Please retain the original copy of this form for you records.*

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**Worksheet for Medical/Dental/Vision Expenses**
Use this worksheet to estimate your reimbursement of "out-of-pocket" medical, dental and vision expenses for the year. Remember:

- You can include unreimbursed expenses for spouse and dependents.
- This is only a partial list from the "List of Eligible Expenses."
- See IRS publication 502 "Medical and Dental Expenses" for specifics on what the IRS allows.
- Focus on the kinds of expenses you and your family normally have or have scheduled for the upcoming year.

Remember – you will not get a refund of unused money that remains in your account. It's better to be slightly conservative when determining the total deduction amount.

| | |
|---|---|
| Acupuncture | $_____ |
| Chiropractic care | $_____ |
| Contact lenses and solutions | $_____ |
| Co-insurance | $_____ |
| Co-payments for office visits | $_____ |
| Co-payments for prescriptions | $_____ |
| Deductibles | $_____ |
| Dental care expenses (routine) | $_____ |
| Dental care expenses (fillings/other services ) | $_____ |
| Eyeglasses and prescription sunglasses | $_____ |
| Fitness club membership if necessary for medical reasons | $_____ |
| Fitness equipment if necessary for medical reasons | $_____ |
| Hearing Aids | $_____ |
| Immunizations and inoculations | $_____ |
| Infertility treatment including in-vitro fertilization | $_____ |
| Laser eye surgery | $_____ |
| Orthodontic expenses | $_____ |
| "Over the counter" eligible items | $_____ |
| Psychiatric treatment/counseling | $_____ |
| Other | $_____ |
| Total expenses: | $_____ |

**"Over the Counter"** products for Section 125 Health Care Reimbursement Accounts
Drugs & Medicines sold "over the counter" such as aspirin, cold medicine, bacitracin etc. are now eligible for reimbursement through your Section 125 Plan effective January 1, 2020.

**Not Eligible for reimbursement** (partial list)
Baby wipes & diapers Dental floss Ear treatments Toothpaste
Moisturizers & powders Deodorants Mouthwash Vitamins (general health)
Shampoo Soap Teeth whitening/bleaching

Call ABS at 1-877-732-8125 with any questions.
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