Vantage Flex LLC
413 10th Ave.
Menominee, MI 49858
800-871-9011

ENROLLMENT/ CHANGE OF STATUS

SECTION 1 — SUBSCRIBER INFORMATION - COMPLETE SECTION 1 THROUGH 3

Social Security Number	Subscriber Last Name ☐ check if new	Subscriber First Name	MI
Home Street Address ☐ check if new	City	State	Area Code/Home Phone
Zip Code	County	Current Marital Status ☐ Single ☐ Married	Area Code/Work Phone

SECTION 2 — SUBSCRIBER

List all persons to be enrolled / terminated:

	Circle One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH	SOCIAL SECURITY #
Subscriber	Add Delete				☐ M ☐ F		
Spouse	Add Delete				☐ M ☐ F		
Dep-1	Add Delete				☐ M ☐ F		
Dep-2	Add Delete				☐ M ☐ F		
Dep-3	Add Delete				☐ M ☐ F		

Do you, your spouse or dependent(s) maintain other health coverage besides Medicare? ☐ NO ☐ YES. If Yes, please indicate who on the line below:

Other coverage:

SECTION 3 — HRA SIGNATURE

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I also understand that my HRA funds are subject to my employer's plan provisions and current tax law where applicable.

Subscriber Signature	Signature Date	Remarks

SECTION 4 — FSA SIGNATURE

With regard to my pay reductions under this agreement, I understand that:

- Expenses for reimbursement must be incurred during the plan year.
- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my reduction will automatically be adjusted.
- I cannot change or revoke this pay reduction agreement at any time during the year unless I have a change in status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, HIPPA qualifying changes, termination or commencement of employment of my spouse's employment status.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections. If I do not complete and return a new election form at that time, I will be treated as having elected to continue only my insured benefits then in effect for the new plan year.
- Dependent care reimbursement will be available only for qualifying dependent care expenses as described in the Internal Code Section 129, and I understand I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this program. I further acknowledge that the total election for me and my spouse cannot exceed the amount outlined in the employer plan document.

I understand that by signing and submitting this form, I am making an irrevocable election for the Plan year indicated below.

Subscriber Signature	Signature Date	Remarks

SECTION 5 — COVERAGE

CHECK AND COMPLETE APPROPRIATE BOXES

Group Name			HRA Coverage: ☐ Single ☐ Two Person ☐ Family ☐ Other FSA Coverage: Annual Election _____ Number of Pay Periods _____ Pay Period Election _____
Plan Year			Group Health Insurance: Annual Election _____ Number of Pay Periods _____ Pay Period Election _____ Dependent Care: Annual Election _____ Number of Pay Periods _____ Pay Period Election _____
ENROLLMENT:	Effective Date:	Date of Hire or Full Time Status:	☐ New ☐ Rehire ☐ Open Enrollment ☐ HIPAA Qualifying Event (describe event): _____
REASON FOR CHANGE:	Effective Date:		☐ Marriage ☐ Name Change ☐ Address Change ☐ HIPAA Qualifying Event (describe event): _____ ☐ Dependent(s) ☐ Loss of Coverage ☐ Transfer
CANCEL COVERAGE:	Last Date of Coverage:		☐ Contract **REASON:** ☐ COBRA ☐ Dependent Over Age ☐ Left Employment ☐ Spouse ☐ Divorce ☐ Death ☐ Other: _____ ☐ Dependent(s) list in Section 2 ☐ Retired ☐ Other Insurance _____

FAX TO: 866-511-5503