Sec. 125
HCR & DCR with Limited HCR Enrollment **IRS Section 125**

Advanced Benefit Strategies
Your Flexible Benefit Specialists

Health Care Reimbursement (HCR) Account & Dependent Care Reimbursement (DCR) Account

I. 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: $_____ **OR**

☐ Yes, I elect the **LIMITED** Health Care Reimbursement (LMT) due to participation in a HSA: Annual Election: $_____

☐ No, I do not want to participate.

IV. Certification

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) and/or Limited Health Care Reimbursement (LMT) 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 $	
☐ 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 and provide a photocopy to ABS.

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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 asprin, cold medicine, bacitracin etc.
now require a prescription from your doctor to be eligible for reimbursement through your Section 125 Plan.

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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