

**Enrollment Form**  
**Richmond Fitness Health Reimbursement Plan**

**Effective Date:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_  
 (Last, First, Middle Initial)

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
 (Street or PO Box)

Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
 (City, State ZIP Code)

Marital Status (check one): [ ] Single [ ] Married

<u>Covered Dependent Names</u>	<u>Gender</u>	<u>Birth Date</u>	<u>Social Security Number</u>	<u>Relationship to Employee</u>
_____	_____	___/___/___	____-____-____	_____
_____	_____	___/___/___	____-____-____	_____
_____	_____	___/___/___	____-____-____	_____
_____	_____	___/___/___	____-____-____	_____

**Health Reimbursement Options (Coordinating with an HSA) - Select one option**

- [ ] Standard Health FSA - I am not enrolled in an HSA plan (nor are any of dependents listed on this form) and wish to receive all the benefits of this HRP.
- [ ] Employee Only Health FSA option - My spouse (and children) is/are enrolled in an HSA with his/her employer but I am not covered under their plan. With this option, I may submit receipts for myself but not my spouse or children.
- [ ] Employee-Plus-Children Health FSA option - My spouse is enrolled in an HSA with his/her employer but neither myself (nor my children) is/are covered under their plan. With this option, I may submit receipts for myself and my eligible children.

**Standard Payroll Schedule**

The following is a list of pay days that will occur during the Plan Year (From 01/01/2022 to 12/31/2022). You may use it to count the number of pay periods that will occur while you are on the plan and calculate your annual reduction amount.

1/10/2022, 1/25/2022, 2/10/2022, 2/25/2022, 3/10/2022, 3/25/2022, 4/10/2022, 4/25/2022, 5/10/2022, 5/25/2022, 6/10/2022, 6/25/2022, 7/10/2022, 7/25/2022, 8/10/2022, 8/25/2022, 9/10/2022, 9/25/2022, 10/10/2022, 10/25/2022, 11/10/2022, 11/25/2022, 12/10/2022, 12/25/2022

**Annual Reduction**

You are reducing your annual compensation to pay for eligible health costs that may not be covered by our benefit plan(s). In essence, you will be paying for these expenses on a pre-tax basis. This is a voluntary plan and the amount you designate as your Annual Salary Reduction should be conservative. Remember, if you do not utilize the funds during the Plan Year (and grace period, if any), you lose them. The maximum Annual Salary Reduction is \$2,750.00 for the 2022 Plan Year.

<u>Entry Date into the Plan (First Payroll Reduction)</u>	<u>Number of Remaining Pay Periods</u>	<u>Desired Reduction per Pay Period</u>	<u>Annual Reduction Amount (Pay Periods X Desired Reduction)</u>
___/___/___	_____	\$ _____	\$ _____

**Salary Reduction Agreement**

I have read and understand the Explanation of Benefits detailing the Richmond Fitness Health Reimbursement Plan (HRP). With this authorization, I am directing Richmond Fitness to reduce my annual compensation by the Annual Reduction Amount shown and reimburse me upon submitting eligible receipts. By reducing my annual compensation, I am essentially paying for uncovered benefits with pre-tax dollars. I understand that this annual reduction is irrevocable and cannot be changed unless a "Change in Life Status" is experienced.

\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 (Date)