

# Section 125 Cafeteria Plan

## Change in Status Form

Complete this form when a change in status has occurred which affects your Cafeteria Plan election. All changes must be due to and consistent with the change in status.

Company Name _____
Employee Name _____
Social Security Number _____ Phone _____
Employee Address _____
Effective date of change _____ If terminating, date of last deduction _____

As a participant in the Cafeteria Plan, I am entitled to revoke my prior benefits election and enter into a new election in the event of certain changes in status. I understand that the change in my benefits election must be due to and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

### I certify that I have incurred the following change in status:

#### Change in Marital Status

- Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment.

#### Change in Number of Tax Dependents

- Change in the number of tax dependants including birth, adoption, placement for adoption or death of a dependent.

#### Changes in Spouse or Dependent's Eligibility Under an Employer's Plan

- Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status.
- Judgment, decree or order including the imposition of a Qualified Medical Child Support Order.
- Gain or loss of Medicaid or Medicare entitlement.
- Entitlement to COBRA.
- Special requirement relating to the Family and Medical Leave Act (FMLA).

#### Change in Employment Status that Changes Eligibility Status

- Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent.
- Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time, and full-time, a strike or lockout, a change in worksite, or commencement of return from an unpaid leave of absence.
- Change in eligibility due to change in residency of the employee, spouse or dependent.

#### Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only)

- Significant cost increase in your or your dependent's coverage.
- Significant curtailment of your or your dependent's coverage.
- Addition or elimination of benefit package option under your or your dependent's employer's plan.
- Change in coverage or open enrollment of spouse or dependent under other employee's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan.
- Dependent care provider is replaced by another.

### Please change my election(s) as follows:

#### Premium Savings Account

Change insurance premiums to \$\_\_\_\_\_ per pay period.

#### Health Care Expense Account

Change my annual election for my Health Care Expense Account from \$\_\_\_\_\_ to \$\_\_\_\_\_. My new per pay period will be \$\_\_\_\_\_ effective with the \_\_\_\_\_ payroll.

#### Dependent Care Assistance Program

Change my annual election for my Dependent Care Assistance Program from \$\_\_\_\_\_ to \$\_\_\_\_\_. My new pay per period election will be \$\_\_\_\_\_ effective with the \_\_\_\_\_ payroll.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

#### Accepted and agreed to by:

\_\_\_\_\_  
Company Representative

\_\_\_\_\_  
Date

# Medical Expense Reimbursement Account Employee COBRA Notice & Election Form

Date \_\_\_\_\_

Company name \_\_\_\_\_ Employee name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Phone \_\_\_\_\_

Employee address \_\_\_\_\_  
Street Address City State Zip

This is to inform you that although you can no longer be covered under our Unreimbursed Medical Expense reimbursement plan, as of \_\_\_\_\_, \_\_\_\_\_, you may continue your benefits under the plan beyond this date for the remainder of the plan year **provided you have a balance in your account (contributions are more than claims paid) at the time of your qualifying event.** If any dependent of yours was covered under the plan, you may also continue their benefits.

**You have 60 days from the date of this notice to notify us of your election.**

If you elect this option, the benefits will be continued until;

- the end of the plan year following \_\_\_\_\_;
- you become a covered employee under any group health plan that has no limitations or exclusions with respect to any preexisting conditions that you (or your dependent) may have;
- you or your dependent(s) become entitled to Medicare. If you become entitled to Medicare, the continuation coverage period for your dependent(s) begins on the date on which you became entitled to Medicare (or, if applicable, the date of an earlier qualifying event) and extends until the end of the plan year;
- you fail to pay the monthly charge for this coverage on time; or
- our Unreimbursed Medical Expense reimbursement plan is no longer in force;

whichever event is **earliest**.

Before termination of employment, you had elected \$ \_\_\_\_\_ of annual healthcare reimbursement benefits, for which you were contributing \$ \_\_\_\_\_ per pay period through a payroll deduction. You and each of your dependents separately have the right to continue the full amount of the annual benefit by continuing to pay for this coverage. If you elect to continue coverage a single monthly payment of \$ \_\_\_\_\_ (includes a \$ \_\_\_\_\_ service fee charge) will be required, and will cover you and your dependents. However, if you do not elect to continue the coverage but your spouse or dependent(s) do, this monthly amount must be paid by each individual in your family who chooses to continue to be covered under the plan. The initial premium payment will be for the coverage period from the date coverage as an employee terminates to the date you sign this election form or the plan year end, whichever is earliest.

**We must receive your first payment within 45 days of the date you sign this election form.**

Monthly payments are due on the first day of the month. If your first payment, or any subsequent monthly payment, is not received on time, you will lose your option to continue coverage. You have a 30 day grace period in which to pay premiums due.

Please complete the bottom portion of this notice. Keep a copy for your records and return the original copy to:

**PIOPAC Fidelity  
1132 Bishop St. Suite 2101  
Honolulu, HI 96813**

- I wish to continue my employee benefits under your Medical Expense Reimbursement plan for myself and my spouse and dependent(s)  Yes  No

- The following family members wish to continue individual coverage under your Medical Expense Reimbursement plan:  
*Spouse/Dependent Name* *Monthly Amount*

\_\_\_\_\_

\_\_\_\_\_

- My first payment is enclosed  Yes  No
- I will make my first payment within 45 days  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT:** In order that your coverage may continue, we must receive:

1. A completed copy of this notice by \_\_\_\_\_.
2. Your first payment within 45 days following the date you sign this form.

# Medical Expense Reimbursement Account Employee COBRA Notice & Election Form

Date: **05/05/05 (1)**

Company name: **XYZ Distributors (2)** Employee name: **Jane Doe (3)**

Social Security Number: **123-45-6789 (4)** Phone: **808-123-4567 (5)**

Employee address: **123 ABC Street (6)** **Honolulu (7)** **HI (8)** **96813 (9)**  
Street Address City State Zip

This is to inform you that although you can no longer be covered under our Unreimbursed Medical Expense reimbursement plan, as of **Friday, 05/20/05 (10)**, you may continue your benefits under the plan beyond this date for the remainder of the plan year **provided you have a balance in your account (contributions are more than claims paid) at the time of your qualifying event.** If any dependent of yours was covered under the plan, you may also continue their benefits.

**You have 60 days from the date of this notice to notify us of your election.**

If you elect this option, the benefits will be continued until;

- the end of the plan year following **Friday, 05/20/05: (11)**
- you become a covered employee under any group health plan that has no limitations or exclusions with respect to any preexisting conditions that you (or your dependent) may have;
- you or your dependent(s) become entitled to Medicare. If you become entitled to Medicare, the continuation coverage period for your dependent(s) begins on the date on which you became entitled to Medicare (or, if applicable, the date of an earlier qualifying event) and extends until the end of the plan year;
- you fail to pay the monthly charge for this coverage on time; or
- our Unreimbursed Medical Expense reimbursement plan is no longer in force;

whichever event is **earliest.**

Before termination of employment, you had elected **\$1,300.00 (12)** of annual healthcare reimbursement benefits, for which you were contributing **\$50.00 (13)** per pay period through a payroll deduction. You and each of your dependents separately have the right to continue the full amount of the annual benefit by continuing to pay for this coverage. If you elect to continue coverage a single monthly payment of **\$127.50 (14)** (includes a **\$2.50 (15)** service fee charge) will be required, and will cover you and your dependents. However, if you do not elect to continue the coverage but your spouse or dependent(s) do, this monthly amount must be paid by each individual in your family who chooses to continue to be covered under the plan. The initial premium payment will be for the coverage period from the date coverage as an employee terminates to the date you sign this election form or the plan year end, whichever is earliest.

**We must receive your first payment within 45 days of the date you sign this election form.**

Monthly payments are due on the first day of the month. If your first payment, or any subsequent monthly payment, is not received on time, you will lose your option to continue coverage. You have a 30 day grace period in which to pay premiums due.

Please complete the bottom portion of this notice. Keep a copy for your records and return the original copy to:

**PIOPAC Fidelity  
1132 Bishop St. Suite 2101  
Honolulu, HI 96813**

- I wish to continue my employee benefits under your Medical Expense Reimbursement plan for myself and my spouse and dependent(s)  Yes  No

- The following family members wish to continue individual coverage under your Medical Expense Reimbursement plan:  

<i>Spouse/Dependent Name</i>	<i>Monthly Amount</i>
	<b>\$227.50 (16)</b>

- My first payment is enclosed  Yes  No
- I will make my first payment within 45 days  Yes  No

▪ Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT:** In order that your coverage may continue, we must receive:

1. A completed copy of this notice by **Wednesday, 06/01/05. (17)**
2. Your first payment within 45 days following the date you sign this form.

**(PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS)**

**Calculation of COBRA premium:**

**Plan Year 8/1/04 to 7/31/05; 26 Pay Periods; Term date 5/20/05:**

**Term Employee:**

\$1,300.00	Annual Elected Amount
\$1,050.00	Total Contributions to date
\$250.00	Remaining Contributions due
2	Remaining Months of Coverage
\$125.00	Monthly Contribution
\$2.50	Service Fee Charge
\$127.50	EE Monthly COBRA premium

**Dependent:**

\$1,300.00	Annual Elected Amount
\$850.00	Total Disbursements to date
\$450.00	Remaining Coverage Allowed
2	Remaining Months of Coverage
\$225.00	Monthly Contribution
\$2.50	Service Fee Charge
\$227.50	Beneficiary Monthly COBRA premium

**Information to Complete**

05/05/05	Date form prepared.	(1)
XYZ Distributors	Company Name	(2)
Jane Doe	Employee Name	(3)
123-45-6789	Employee SS #	(4)
808-123-4567	Employee Contact Phone #	(5)
123 ABC St.	Employee Address	(6)
Honolulu	Employee City	(7)
HI	Employee State	(8)
96813	Employee Zip Code	(9)
Friday, 5/20/05	Termination date	(10)
Friday, 5/20/05	Termination date	(11)
\$1,300.00	Annual Election Amount	(12)
\$50.00	Per Pay Period Deduction	(13)
\$127.50	EE Cobra Premium	(14)
\$2.50	Monthly Service Fee Charge	(15)
\$227.50	Beneficiary Monthly COBRA premium	(16)
Wed, 6/1/05	1 <sup>st</sup> day of the month coverage is to continue	(17)

# PIOPAC Fidelity

## THIRD PARTY ADMINISTRATION

*“Security, Integrity, Trust”*

### ***AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT***

I authorize PIOPAC Fidelity to initiate credit entries and, if errors occur, I authorize correcting entries to my account indicated below.

Financial Institution Name/ Location	Transit Routing Number	Account Number	Type of Account Checking or Savings

This authority is to remain in full force until I terminate this authorizations in writing.

Print Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_

**Note: Please attach a voided check to this authorization.**

**Return to: PIOPAC Fidelity – 1132 Bishop Street #2101 – Honolulu, HI 96813-2830**

Mr. or Mrs. Direct Deposit 1234 Hawaii Street Cityville, HI 54321		_____
Pay to the Order of _____	-----S-A-M-P-L-E-----	\$ _____
		_____ Dollars
Bank of HONHI ( 1 ) 123 Kamehameha Rd.		
:1 2 3 4 5 6 7 8 9 -: ( 2 )	:0 0 0 1-:	:1 2 - 3 4 5 6 7 8-: ( 3 )

**( 1 ) – Financial Institution Name / Location**

**( 2 ) – Transit Routing Number**

**( 3 ) – Account Number**

# PIOPAC Fidelity

Third Party Administration  
*"Security, Integrity, Trust"*

To: All Direct Deposit Participants

RE: Direct Deposit Notification

Below is an explanation of our guidelines for processing direct deposit payments. We suggest that all employees interested in this type of reimbursement be informed of PIOPAC Fidelity's claims reimbursement process.

Direct deposit reimbursements are remitted as they are received. A claim reimbursement must be completely processed and prepared prior to the 12:00 PM deadline. A direct deposit notification is then mailed out to the employee.

**PLEASE CONTACT YOUR BANK INSTITUTION FOR CONFIRMATION OF DEPOSIT.**

It is important to understand that even though it is an efficient form of reimbursement, it is not automatic. Without payroll or for other reasons beyond our control, it should not be assumed that the money has been deposited in the account on a specific date. Not receiving a direct deposit notification is an indication that funds have not been deposited.

We recommend direct deposit to all our FSA participants. It is a proven, expedient and reliable processing method. If you have any further questions or concerns, please contact our office at (808) 526-0097, ext. 201.

## Initializing Your Account on MyFlexOnline Web Site

1. Open a web browser (i.e.: Internet Explorer) and go to [www.myflexonline.com](http://www.myflexonline.com).  
\*\*Note\*\* You can bookmark this page in your browser for future use.
2. If you are a New User, click on “NEW USER” to setup your account.
3. Fill out each field (Social Security Number, Date of Birth, and distinct email address in proper format provided). Complete Username, Create Password, and then confirm Password. Then select a Hint Question using the drop down menu (down pointing arrowhead.) Complete answer to question. Click on Continue to view account.

## MyFlexOnline Claim Request

After initializing your account, select “Request a Payment” to generate a claim form. Upon completion of all payment items, print form, sign, date and fax to 536-0430 along with receipts.

https://www.myflexonline.com/ICE.aspx

MyFlexOnline [Log Out](#)

[View Account](#) [Request Payment](#) [Flex Debit Card](#) [User Info](#) [Contact Us](#) [Help](#)

[Create Claim](#) [Filing Help](#) [Qualified Expenses](#)

### Create Claim

Please enter line detail for the first item and then click **Add An Item**. Your claim items will then be displayed. To add multiple items, continue to enter line detail and click **Add An Item**.

Claim Type	Start mm/dd/yy	End mm/dd/yy	Description	Amount	Dependent
Select...				\$	

[ADD AN ITEM](#)

#### Detailed Instructions

Step 1: Select a claim type from the drop down list, enter start date of service, end date of service, description of service and amount. Please note: dates of service are the dates the service occurred, not when paid. If this is for dependent care, please enter the dependent's name.

Step 2: Click **Add an Item**.

Step 3: Enter additional lines by repeating Step 1 and Step 2. Please enter an individual line for each item purchased.

Step 4: When finished entering items, click **View Form**.

Current as of 1/5/2009 7:37:04 PM

[Privacy Policy](#) | [Copyright & Disclaimer](#)

## **NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION**

**This notice is in effect as of April 14, 2003**

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

#### **STATEMENT OF OUR DUTIES**

We are required by law to maintain the privacy of your personal health information and to provide you with this notice of our privacy practices and legal duties. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the personal health information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mail.

#### **STATEMENT OF YOUR RIGHTS**

You have a right to know how we may use or disclose your personal health information. This notice informs you of those uses and disclosures. There are certain uses and disclosures of your personal health information that we are permitted or required to make by law without your permission. For all other uses and disclosures, we first must obtain your permission. In addition, you have the following rights:

- The right to request that we place additional restrictions on our uses and disclosures of your personal health information. However, we are not obligated to agree to impose any such additional restriction.
- The right to access, inspect and copy the protected information pertaining to you that we maintain in our files about you, and the right to have us correct or amend any information that we create in error. Requests to access or amend your health information should be sent to the contact person and address provided in below.
- The right to receive an accounting of the disclosures of your personal health information that we make for purposes other than activities related to your treatment and/or claim, or our payment functions or other health care operations.
- The right to request that you receive communications of personal health information in a confidential manner.

#### **INFORMATION WE COLLECT ABOUT YOU**

We collect the following categories of information about you from the following sources:

- Information that we obtain directly from you, in conversation or on Request for Reimbursement application or other forms that you fill out.
- Information that we obtain as a result of our transactions with you.
- Information that we obtain from your medical records or from medical professionals.
- Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other administration related needs.

#### **PERMISSIBLE USES AND DISCLOSURES OF PROTECTED INFORMATION**

The following categories describe different ways that we use and disclose PHI:

We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

We may use or disclose your protected health information without your written permission for other purposes permitted or required by law, including:

- As authorized by and to the extent necessary to comply with workers compensation or other no-fault laws.
- To a health oversight agency for activities including audits or civil, criminal or administrative proceedings.
- To a public health authority for purposes of public health activities (such as to the Food and Drug Administration to report consumer product defects).
- To a law enforcement official for law enforcement purposes or in response to a court order or in the course of any judicial or administrative proceedings.
- To organ procurement organizations, or to other entities for approval research purposes.
- To a government authority, including a social service or protective services agency, authorized to receive reports of abuse, neglect or domestic violence.

We may use or disclose your protected health information after we have given you an opportunity to object and you have not objected. For example, if you do not object, we may use limited information about you to maintain an office directory, to notify family members or any other person identified by you regarding issues directly related to such person's involvement with your care or payment for that care, or claim or in emergency circumstances.

**You are responsible for inappropriate use or disclosure of your information that occurs due to your selected method of transmitting this information (e.g. fax, e-mail, or any other electronic form).**

All other uses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

#### **COMPLAINTS ABOUT MISUSE OF HEALTH INFORMATION**

You may complain either directly to PIOPAC Fidelity or to the Secretary of Health and Human Services if you believe that your rights with respect to our protection of your health information have been violated. To file a complaint to PIOPAC Fidelity, submit your complaint in writing that includes as many details (such as names and dates) as possible. Mail to our Privacy Official, Patricia M. Lum, 1132 Bishop Street, Suite 2101, Honolulu, Hawaii 96813. You will not be retaliated against in any way for filing a complaint.

#### **OUR PRACTICES REGARDING CONFIDENTIALITY AND SECURITY**

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

#### **OUR POLICY REGARDING DISPUTE RESOLUTIONS**

Any controversy or claim arising out of our relating to our privacy policy, or the breach thereof, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

#### **CONTACT PERSON FOR FILING COMPLAINT OR OBTAINING FURTHER INFORMATION**

If you want to file a complaint or have questions or need further assistance regarding this Notice, you may contact PIOPAC Fidelity's Privacy Office by writing to: PIOPAC Fidelity, Attn: Patricia M. Lum, 1132 Bishop Street, Suite 2101, Honolulu, Hawaii 96813, or by calling (808) 792-5248, for outer island, call (800) 777-0284 ext. 248.

# PIOPAC Fidelity

Third Party Administration  
"Security, Integrity, Trust"

## Notice of Employee Termination

PLEASE USE THIS FORM TO NOTIFY PIOPAC FIDELITY OF ANY TERMINATIONS OF EMPLOYEES WITH UNREIMBURSED MEDICAL, DEPENDENT DAY CARE OR PREMIUM DEDUCTIONS.

**\*\* FAILURE TO DO SO COULD RESULT IN FUNDS BEING IMPROPERLY RELEASED. \*\***

Please fax this form to PIOPAC Fidelity at (808) 536-0430

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Termination Date: \_\_\_\_\_

Date of Last Paycheck Deduction: \_\_\_\_\_

Benefit Termination Date: \_\_\_\_\_

Total **\*\* URM Plan Year to Date** Deductions: \$ \_\_\_\_\_

Total DDC **Plan Year to Date** Deductions: \$ \_\_\_\_\_

Total AFLAC **Plan Year to Date** Deductions: \$ \_\_\_\_\_

Total LIFE **Plan Year to Date** Deductions: \$ \_\_\_\_\_

Total TRANSPORTATION **Plan Year to Date** Deductions: \$ \_\_\_\_\_

**\*\* URM Benefit Only:**

URM Participant account is Underspent and COBRA notice sent to covered employee and qualified beneficiaries.

URM Participant account is Underspent and we are not subject to COBRA.

YOU WILL RECEIVE A CALL OR EMAIL FROM OUR OFFICE TO VERIFY THAT WE RECEIVED THIS FORM FROM YOUR OFFICE. IF A CALL OR EMAIL IS NOT RECEIVED WITHIN ONE BUSINESS DAY PLEASE CONTACT OUR OFFICE.

\_\_\_\_\_  
Signature (FSA Contact)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

• 1132 Bishop Street Suite 2101 • Honolulu, HI 96813 •  
• Phone (808) 526-0097 • Toll Free (800) 777-0284 • Fax (808) 536-0430 •



## Flexible Spending Account Participant Handbook

Provided by  
PIOPAC Fidelity  
for your Employer's Plan



**PIOPAC Fidelity**  
**Third Party Administration**  
"Security, Integrity, Trust"

# PIOPAC Fidelity Flexible Spending Account Participant Handbook

## Welcome to PIOPAC Fidelity Administrative Services!

We are dedicated to providing superior service to our customers and are delighted to serve as your cafeteria plan service provider. Our role is to process your requests for Reimbursement according to the plan designed by your employer, who is the plan sponsor and plan administrator. All benefits are funded by your employer through your salary redirection. Flexible Spending Account (FSA) benefits are paid by your employer and not insured or paid by PIOPAC Fidelity.

- There are two types of FSAs: The first is unreimbursed medical (URM) and the second is dependent day care (DDC).
- Your participation in an FSA program allows a portion of your salary to be redirected to provide reimbursement for these types of expenses.
- At the beginning of each plan year, you elect a specific dollar amount for each FSA you wish to participate in (not to exceed your plan maximum) for healthcare FSA or (IRS maximum) for dependent day care.
- Participation in one or both FSAs can save you money by reducing your taxable income. You pay no Federal, State or Social Security because taxes will be calculated after the amount is deducted from your salary.

## Use of Personal Information

Your privacy is important to us. PIOPAC Fidelity will follow applicable law with regard to the use and disclosure of your personal information. As set forth in your claim form, by enrolling in the FSA, you authorize us to use and disclose your personal information in connection with administering the plan and for other purposes permitted by law.

*\*Use discretion when faxing your medical information to us. You bear full responsibility for any inappropriate use or disclosure that may arise as a result of your transmission of information to PIOPAC Fidelity.*

### For Inquiries

(808) 526-0097 or

Toll free (800) 777-0284

Ext. 233 or 242

To Submit Claims by Fax

(808) 536-0430

To Submit Claims via a PDF file

Email to [fsaclaims@piopac.com](mailto:fsaclaims@piopac.com)

Before submitting your claim, make sure you have had the service(s).

### To File Your Claim

1. Complete a claim form, and be sure to sign and date it.
2. Attach legible receipt(s) from the service provider or EOB (Explanation of Benefits) showing:
  - \* A description of the service or a List of supplies furnished.
  - \* The charge(s) for each service.
  - \* The date(s) of service.
  - \* The name of the person(s) receiving the service.
  - \* For RX the prescription drug Name.

### No Waiting in Line!

We recommend direct deposit to all of our FSA participants as we feel it is a more efficient and reliable processing method. If by chance check payment is misplaced or lost in the mail, there will be service fee charged to have the payment replaced.

## Healthcare FSA

### Common Eligible Expenses:

- Co-Payments
- Co-Insurance
- Deductibles
- Over-the-Counter Medical Supplies
- Dental Treatment
- Orthodontia
- Lab Fees
- X-Rays
- Vision Expenses
- Lasik Surgery
- Physical Therapy
- Chiropractor Services
- Acupuncture
- Eye Contact Solution
- Eye Drops
- Band aids
- Birth Control
- Reading Glasses
- Insulin & diabetic Supplies
- Catheters
- Braces & Supports

### Common Ineligible Expenses:

- Over-the-Counter (OTC) Drugs & Medicines
- Cosmetic Surgery
- Teeth Whitening
- Botox
- Non Prescribed Vitamins and Supplements
- Toiletries
- Medical Insurance Premiums
- Health Club Membership Fees

Almost every person has a number of necessary and predictable expenses that are not paid by their insurance plans. You can save money by putting that amount directly into your Healthcare FSA. The FSA will help you pay for these predictable expenses with your pre-tax dollars. Over-the-counter drugs to treat a medical condition is now an allowable FSA expense.

## Eligible Expenses

With the FSA, you can pay out-of-pocket health care expenses for yourself, your spouse and all of your dependents for health, dental and vision care expenses. The services must be incurred while you are actively participating in the FSA plan. The eligible expenses may be reimbursed regardless of whether you, your spouse or dependents are covered by your employer's medical, dental or health plan.

Expenses for medical care will be limited to expenses incurred primarily for the prevention or improvement of a physical or mental defect or illness. An expense that is merely beneficial to your general health is not an eligible expense. It must be an expense to treat a medical condition.

## Ineligible Expenses

Some expenses that you incur during your plan year may not be eligible for reimbursement under current IRS regulations.

- ▶ **Expenses not yet rendered**—Expenses that have been paid, but not yet rendered (i.e. prepayment of services) cannot be reimbursed until the service is rendered. Expenses don't necessarily have to be PAID, but merely incurred.
- ▶ **Premiums for insurance**—Premiums and payments to insurance policies are not eligible for reimbursement.
- ▶ **Expenses paid by another plan or third party**—Expenses that have already been paid by an insurance company or other reimbursement plan are not eligible for reimbursement through your FSA plan.
- ▶ **Expenses incurred after termination/separation from your employer**— If you are no longer participating in the FSA plan through your employer (termination, resignation, etc) any claims incurred after your participation ends are not eligible for reimbursement.
- ▶ **Effective January 1, 2011 Medical FSA may no longer be used to Purchase OTC drugs and medicines (other than insulin) without A directive (prescription) from a medical provider.**

## Dependent Care FSA

The Dependent Care FSA allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars while you (and your spouse) are working

### Common Eligible Expenses:

- Day Camps
- Before/After School Care
- Baby-Sitters
- Day Care Centers
- Au Pair
- Nanny
- Nursery
- Pre-School

### Common Ineligible Expenses:

- Registration Fees
- Overnight Camps
- Care for child while not working
- Kindergarten
- Tuition Expenses
- Food/Activity expenses if Separate from cost of care
- Care provided by anyone Under age 19

## Eligibility Requirements

Eligible dependents must be claimed as an exemption on your tax return. These dependents can include step-children, grandchildren, adopted children, or foster children. In a divorce situation, you must have custody of the child in order for the child to be considered an eligible dependent. Under IRS regulations, eligible dependents are further defined as: under the age of 13, and/or physically or mentally unable to care for themselves, such as a disabled spouse, disabled child or elderly parents that live with you.

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible dependents are receiving care. If you are married, your spouse must be working at the time services are rendered, full-time student for at least 5 months during the year, or mentally or physically disabled and unable to provide care for himself or herself. In the event of a divorce, the non-custodial parent cannot make a claim unless they have custody for 6 or more months during the year.

## Eligible Expenses

Eligible dependent care expenses are those expenses you must pay for the care of dependent so that you and your spouse can work. The care may be provided in your home or at a licensed center outside of your home. If the care is in your home, the service cannot be provided by another child of yours under the age of 19, by your spouse, or by your dependents.

## Ineligible Expenses

Only those dependent care expenses that enable you and your spouse to work are eligible. Some expenses that you incur during your plan year may not be eligible for reimbursement under current IRS regulations.

- ▶ Educational Costs
- ▶ Weekend/Evening—out Babysitting
- ▶ Transportation, books, clothing, food, activities, entertainment and Registration fees are ineligible if these expenses are shown Separately on your bill.

PIOPAC Fidelity Flexible Spending Account Participant

## take care® Flex Benefit Card



### Receiving your take care® Card

You will automatically receive One (1) take care® Card in your name when you enroll, and the card will be mailed Directly to your home address. To order a second card for your spouse or dependent you must order it online at [www.myflexonline.com](http://www.myflexonline.com) at no additional cost.

The **take care®** Flex Benefit Card provides easy and instant access to your FSA funds, thereby eliminating the need to pay your expenses “out – out-pocket” at the time of service. This enhancement to the FSA program can minimize the chance of forfeiting funds. Additionally, there’s no Waiting for reimbursement anymore, because you are accessing your FSA funds at the point of sale.

## Using your take care® Card

The card will only work at qualified merchants who accept Visa®, such as doctor’s offices, hospitals, pharmacies, dental offices, vision providers and health care related providers. Card will also work at qualified retail merchants that have implemented the IRS mandatory cash register system (IIAS) Inventory Information Automatic System.

Simply present the **take care®** Card at the time of payment to make your purchases. The provider will be paid and your account balance will automatically be adjusted for the amount. Be sure to get a receipt showing your purchase, as you may be asked to present it at a later date. After you enroll, we will send a Welcome Package with detailed instructions on using the take care® Card. Need to check your balance? That’s easy, just log into your account at [www.myflexonline.com](http://www.myflexonline.com). You will have access to balance, claim and payment information 24 hours a day, 7 days a week. Have a question about your account? You can browse our Frequently Asked Questions (FAQ) or call or email our Customer Service Department from 8:00 a.m. to 4:30 p.m. Monday through Friday.

## Providing Documentation for take care® Flex Benefit Card Purchases (substantiation)

The IRS requires that you keep all receipts for your FSA expenses, regardless of the method of payment. Typically, when you pay with your **take care®** card at a pharmacy or doctor’s office, receipts may not be required for your co-payment if you are on a HMO plan, but you must still obtain and keep a receipt for the purchase. If a receipt is required, PIOPAC Fidelity will notify you via email asking for the receipt. If you fail to substantiate by providing a receipt to us for the purchase, your card may be suspended until the necessary receipt is received. If no response via email a notice will be mailed to your home.

PIOPAC Fidelity Flexible Spending Account Participant

# General IRS Rules & Information

The following rules apply to both DDC and URM FSAs

## Election Irrevocability

You may not make changes before the beginning of the next plan year unless there is a qualified change in status (as permitted by your plan) that affects Eligibility.

Qualified changes in status may include:

- Change in employee's legal marital status
- Change in number of tax dependents
- Change in employment status that affects eligibility
- Dependent satisfies or ceases to satisfy eligibility requirements
- Change in residence that affects eligibility
- Judgment, decree, or court order dictating provision of coverage
- Entitlement to Medicare or Medicaid (URM only)
- Change in cost of the benefit (DDC only)
  - \* Addition or elimination of benefit option
  - \* Change in coverage of spouse or dependent under his/her employer's plan
  - \* Significant curtailment of coverage

If a change in status occurs, you may make changes consistent with the qualifying event or as otherwise defined by your Plan Document. See your plan Sponsor for further details about making changes.

## Dollar Limits

### DDC Account:

This reimbursement (when aggregated with all other dependent care reimbursements during the same calendar year) may not exceed the least of the following:

- \$5,000, or
- \$2,500, if married but filing separate tax returns

### URM Account:

Your plan sponsor determines the maximum benefit that may be elected. Please see your employer for the maximum benefit amount allowed under your plan.

## Use-it-or-lose-it Rule

Money remaining in your FSA account(s) will not be returned to you at the end of the plan year. Any amount remaining after the end of the runoff or grace period will be forfeited. Because of the use-it-or-lose-it rule, it is important for you to carefully estimate your out-of-pocket URM and DDC expenses for the upcoming plan year.

## Termination of Employment

### DDC Account:

If you have not received reimbursement for all contributions made to your DDC account upon your termination, you may continue to incur expenses during the plan year and submit claims for reimbursement. Generally, you may submit claims through the plan year and runoff period until all of your contributions are used.

### URM Account:

When you terminate employment, your participation in the plan ends and you will no longer be able to incur expenses for reimbursement. Your salary Redirections will end; however, you may still file claims for dates of service that were incurred before your termination as long as they are within your eligible plan year.

## COBRA:

COBRA does not apply to DDC. However, COBRA may apply to your URM account and allow you to continue participation in your URM, thus allowing you to receive reimbursement for medical expenses incurred after your employment termination if:

- The plan sponsor is subject to COBRA, and
- When you terminate employment and you have contributed more for URM than you have received in URM benefits.

*Note: Under COBRA you must elect coverage within 60 days and continue to submit contributions to your employer to continue coverage under your URM account for the current year.*

## The Reimbursement Process

### Claims Processing and Payments

All claim reimbursements are handled with strict adherence to IRS adjudication and reporting regulations. Claims are processed daily and our turn around time upon receipt is 3—5 business days and during peak periods (December—March) 5—10 business days. Your reimbursement check will be mailed to your home address on file. You may also elect to receive payment via direct deposit.

### Minimum Check Amount

The minimum reimbursement check amount is \$15.00 This is excluding end-of-the-year claims which are Processed after the close of the plan year and balance is under \$15.00.

### Online Service to Request For Payment

[www.myflexonline.com](http://www.myflexonline.com)

- ▶ **Reimbursements**—Healthcare/Medical FSA's are pre-funded; therefore, you are eligible to receive reimbursement up to your elected annual contribution from the start of your FSA plan. The healthcare/Medical FSA funds that are reimbursed to you will be recovered as your deductions are taken from your paycheck throughout the plan year. Dependent Care FSA's are NOT pre-funded; therefore, you will only receive reimbursement up to your year-to-date contributions from payroll deductions.
  - ▶ **Payment Method Choice**—You may pay with your take care® Flex Card at the time you incur the expense, or pay the provider out-of-pocket and file a manual (paper) claim to receive a reimbursement
  - ▶ **Manual Claims**—To obtain reimbursement from your FSA, you must complete a manual claim form or use the online service to input your information, and attach all itemized receipts from the service provider. Cancelled checks, bankcard/credit card receipts and credit card statements are NOT acceptable forms of documentation. The receipt must come from the service provider or the Explanation of Benefits from your medical health carrier and must include the following information:
    - For whom the service was incurred
    - Date of service incurred
    - Name of service provider
    - Amount of your out-of-pocket charge incurred
    - Type of service incurred
    - Must identify name of prescription drugs (RX)
- \*PIOPAC Fidelity recommends submitting an Explanation of Benefits (EOB) from your insurance company, if available.
- ▶ **Remember**—You must sign and date all claim forms.

PIOPAC Fidelity Flexible Spending Account Participant

# Expense Estimation Worksheet

This worksheet can help you determine an estimate of your annual expenses for each FSA reimbursement account. Good planning and careful estimating is the best way to take full advantage of your FSA program. Below are examples of allowable expenses to help you. See a list of all allowable expenses on our website at [www.ezflexplan.com/piopac](http://www.ezflexplan.com/piopac).

## Qualifying FSA Expenses

### Healthcare/medical FSA

Deductible	\$	_____
Co-payments	\$	_____
Doctor visits	\$	_____
Prescription Drugs	\$	_____
Over-the-Counter Items	\$	_____
Vision Exams	\$	_____
Glasses	\$	_____
Contacts	\$	_____
Lasik Surgery	\$	_____
Dental Visits	\$	_____
Orthodontia	\$	_____
Lab Fees	\$	_____
Counseling and Therapy	\$	_____
Acupuncture Services	\$	_____
Chiropractor treatment	\$	_____
Miscellaneous	\$	_____
Total Estimated Healthcare	\$	_____
Divide by # of annual pay periods		_____
FSA deduction per pay period	\$	_____

### Dependent Care FSA

Child day-care or preschool	\$	_____
After school programs	\$	_____
Nanny, Au-pair, babysitter	\$	_____
Summer day camp expenses	\$	_____
Adult day-care expenses	\$	_____
Miscellaneous	\$	_____
Total Estimated Dependent Care	\$	_____
Divide by # of annual pay periods		_____
FSA deduction per pay period	\$	_____
TOTAL		_____

# **PIOPAC Fidelity**

**Third Party Administration**

*"Security, Integrity, Trust"*

## **HIPAA PRIVACY COMPLIANCE STATEMENT**

Beginning March 17, 2003 and up through April 14, 2003, PIOPAC Fidelity will mail to all FSA Participants, Plan sponsors and/or Human Resources Director our **NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION**.

PIOPAC Fidelity is not a covered entity under the rules and will not provide Certification form for the plan sponsor to complete and sign.

PIOPAC Fidelity is a Business Associate of the Plan that we administer and our functions are not to modify, amend or terminate the Plan, therefore, PIOPAC Fidelity will not provide any sample or customized Plan Amendments for each Plan Sponsor.

PIOPAC Fidelity has designated Patricia M. Lum as its Privacy Official. She can be reached at telephone number (808) 792-5248 or (800) 777-0284 ext. 248.

PIOPAC Fidelity will provide a notice of our HIPAA Privacy Policy and Procedures to all Plan Sponsors and/or Human Resources Director in writing to inform you on how we safeguard your information.

PIOPAC Fidelity has just completed a HIPAA Privacy Roadmap for Employers and TPA's, an EBIA Tele-Web Seminar to ensure that necessary standards are met. Topics covered were HIPAA Privacy, Compliance, Core Requirements, and our Role as a Business Associate, Scenarios, Functions, and purpose.

PIOPAC Fidelity upon request will provide copies of PHI that we maintain and it must be in writing and signed by participant requesting access. Request forms will be available upon request after April 14, 2003. We may charge a fee for copying and postage.

PIOPAC Fidelity has procedures currently in place for handling and recording of complaints as stated in the **NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION**.

PIOPAC Fidelity's fiduciary responsibility because of the sensitive nature of our business requires that ongoing training be provided to ensure that our employees carry out these practices to protect personal information about our customers and are fully aware that they will be subject to censure and dismissal, or termination for violations of these policies.

• 1132 Bishop Street Suite 2101 • Honolulu, HI 96813 •  
• Phone (808) 526-0097 • Toll Free (800) 777-0284 • Fax (808) 536-0430 •

# **PIOPAC Fidelity**

## **Third Party Administration**

*"Security, Integrity, Trust"*

PIOPAC Fidelity has amended our RSA (Reimbursement Service Agreement) to include Business Associate language according to rule and will be submitted to Plan Sponsor after April 14, 2003 upon renewal of the plan.

PIOPAC Fidelity has implemented an Accounting Disclosure procedure for logging and processing. Request must be in writing and we will only provide accounting for disclosures that we are required to account for.

PIOPAC Fidelity does not enter specific claim information in our system which ensures we are not subject to the EDI rules. We also do not accept enrollment information directly from the participant and then send the information to the employer. All enrollment information is sent from agent and/or employer.

PIOPAC Fidelity does not handle any electronic health information; the security regulations will not affect oral, written or other non-electronic forms. Therefore, the HIPAA data security standards do not apply.

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# **PIOPAC Fidelity**

## **Third Party Administration**

*"Security, Integrity, Trust"*

### **PRIVACY POLICY AND PROCEDURES**

Protecting the privacy and confidentiality of information about our groups and participants is very important to PIOPAC Fidelity. Collectively, we strive to comply with each of the following policy and procedures:

- We do not sell, rent, lease or otherwise disclose personal information of our clients for purposes unrelated to our products and services. The personal information of our clients is of paramount importance to us. Therefore, we provide this information only to our employees, agents and health plan provider as required to allow them to help us develop and provide services.
- We work to ensure information integrity and security using technology tools and design our business practices to help protect the personal information of our clients is properly gathered, stored and processed.
- PIOPAC Fidelity has business policies and practices in place to help ensure that our employees carry out these practices to protect personal information about our clients. Employees are subject to censure, dismissal, or termination for violation of these policies.

**PIOPAC Fidelity provides this notice to let you know about the current privacy practices. You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

#### **Collection of Information**

As part of PIOPAC Fidelity's (PPF) normal operating procedures, PPF need to obtain information to determine an individual's eligibility for reimbursement claims and services. PPF may collect nonpublic personal health information about group and individual clients including:

- Information from clients and group including names, addresses, social security numbers and health information as required to process claims and reimbursements.
- Information about the clients' transactions with PIOPAC, agents or plan administrators regarding claims and payment information.
- Information from employer (including salary and benefits to determine eligibility information), clients' health care provider (including products and premium information), and family members.

• 1132 Bishop Street Suite 2101 • Honolulu, HI 96813 •  
• Phone (808) 526-0097 • Toll Free (800) 777-0284 • Fax (808) 536-0430 •

# **PIOPAC Fidelity**

## **Third Party Administration**

*"Security, Integrity, Trust"*

### **Disclosure of Information**

PIOPAC Fidelity may disclose the nonpublic personal information we collect as described above, as well as information about your transactions with us (such as your policy coverage, premiums, and payment history) to our agents or health care provider who perform services or functions on our behalf. We may also disclose the nonpublic personal information we collect as authorized by you, or as required or permitted by law.

PIOPAC Fidelity will use or share with other parties any nonpublic personal health information about you for any purpose other than disclosures for the performance of insurance functions, claims, and reimbursements, or disclosures that are permitted or required by law, or disclosures that the client authorized.

PIOPAC Fidelity will not disclose any nonpublic personal information about a former client of PIOPAC Fidelity other than as may be required or permitted by law.

### **Confidentiality and Security**

PIOPAC Fidelity will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about our groups and clients. PIOPAC Fidelity maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our client's information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, PIOPAC Fidelity limits access to our clients' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law.



# Request for Reimbursement

FSA  HRA  Debit Card Substantiation

Plan will pay Flexible Spending Account (FSA) before Health Reimbursement Account (HRA)

Participant name (Please type or print): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Participant Address (complete only if new): \_\_\_\_\_  
 \_\_\_\_\_ City State Zip

Employer \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

By submitting this claim form I request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and Conditions stated below; I certify and warrant to PIOPAC Fidelity that these are eligible medical and/or dependent day care expenses that I or my dependents have incurred. (Please read reverse side for instructions.)

=>Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dependent/Child Care

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Name of Dependent (A)	Age	Provider Name (B)	Dates Service Provided (C)	Requested Amount of Reimbursement (D)	PIOPAC Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

### Provider's Certification/Verification

I certify that the above-described dependent care expenses were incurred by the Participant named above.

Business/Provider Signature \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_

## Unreimbursed Medical

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Patient Name (A)	Provider Name (B)	Description of Service (C)	Dates Service Provided (D)	Requested Amount of Reimbursement (E)	PIOPAC Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Cancelled checks or bills showing a previous balance or balance due only are not acceptable.

### Provider's Certification/Verification

I certify that the above-described unreimbursed medical expenses were incurred by the Participant named above.

Medical Provider Signature \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_

### TERMS and CONDITIONS

**I (above named Participant) understand and agree that:**

- medical expenses must qualify as deductible expenses under Internal Revenue Code Section 213(d) and allowed under Prop. Treas. Reg.1.125.2, and cannot be reimbursed by any other source or used as a deduction or credit on my personal income tax return(s).
- dependent care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder.
- the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return(s) using Form 2441.
- I am responsible for inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this information (e.g. fax, e-mail, or any other media).
- I hereby authorize the Plan and its service provider (PIOPAC), and their respective agents, employees, sub-contractors, and assigns to use the information provided above to administer the Plan (including the eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose and all such information as is reasonably required for such purposes.
- I further authorize any provider, insurer or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud.
- I hereby expressly waive and release any claims related to the use, disclosure, or release of information so long as the information is used in furtherance of administering the Plan (including the processing or evaluating my claim for benefits under the Plan) or detecting or preventing fraud.

- This authorization does not and is not intended to in any way limit any right the Plan, PIOPAC, or their respective agents, employees, subcontractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

## **How to File a Request for Reimbursement**

1. Complete the front side of this form, being sure to **sign** and **date** it. Failure to complete **all** areas can result in a delay in processing and claim reimbursement. **Note:** All fields must be filled in completely, do not indicate, "See attached" in any field.
  2. **Do not** submit **Dependent Care** (DDC) or **Unreimbursed Medical** (URM) claims until **after** services are rendered. Verify that the services received are eligible expenses. See below and/or refer to your *Participant Guide to Flexible Spending Accounts*.
  3. Attach legible itemized bills, receipts or Explanation of Benefits (EOB's) which show:
    - The **name** of person(s) receiving service
    - The **date(s)** of service
    - A **description** of service or supplies furnished
    - The **name** of provider(s)
    - The **charges** for each service
- Note: Drug receipts must clearly show the drug name.** Balance due statement and credit card receipts are not valid receipts unless it indicates all of the required information listed above. Never send in receipts without a completed Request for Reimbursement form.
4. The business/provider may sign this form in lieu of attaching a receipt.
  5. If you carry group insurance, first submit expenses to the insurance carrier. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible or coinsurance amounts.
  6. Checks are not written for less than \$15.00. **Requests for less than \$15.00 will be applied to future requests.**
  7. **Please make a copy for your files.**

## **General IRS Eligibility Guidelines**

To qualify for reimbursement from Flexible Spending accounts, expenses must be incurred during **your** Plan Year for which you are requesting reimbursement.

1. **Unreimbursed Medical Account** - can be used for medical expenses for you or your family that are not covered by any other health plan. Items covered include, but are not limited to:
  - major medical co-payments and deductibles (excluding insurance premiums of any kind)
  - certain medical, dental, hearing & vision services (excluding cosmetic procedures)
  - most prescribed drugs, contraceptives, insulin and smoking cessation programs (herbal drugs and over-the-counter drugs may be eligible, if permitted by the Plan and used to treat a medical condition)
  - purchase and rental of most medical devices, including diabetic-related supplies
  - most medical assistance tools for disabilities, such as seeing-eye dogs and text telephone for hearing impairments
2. **Dependent/Child Care Account** - reimbursement for care of your child or other tax dependent while you are at work. For reimbursement services at a dependent care center, the center must comply with all state and local laws.

Specifications for this account are:

- your child must be age 12 or under and resides with you
- your child or other dependent over the age of 12 must be incapable of self support and spend eight hours or more a day in your home
- the individual caring for your child (age 12 and under or other dependent) must not be your tax dependent
- reimbursement cannot exceed \$5,000 annually (\$2,500 if married filing separate returns) or the earned income of you or your spouse, whichever is less

### **TO SUBMIT YOUR COMPLETED FORM:**

**FAX** completed Request for Reimbursement forms to: **(808) 536-0430**

**NOTE:** *Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to PIOPAC.*

**OR**

**MAIL** completed request for reimbursement forms to:

**PIOPAC Fidelity  
FSA Claims Dept.  
1132 Bishop Street Suite 2101  
Honolulu, HI 96813**

**EMAIL** form to [FSAClaims@piopac.com](mailto:FSAClaims@piopac.com)

**NOTE:** *To speed up the process of your claim, please attach all receipts to a full 8x10 sheet of paper.*

**For Customer Service call: (808) 526-0097 ext. 233 or 242 or Toll Free – 800-777-0284**

# PIOPAC FIDELITY

THIRD PARTY ADMINISTRATION

*“Security, Integrity, Trust”*

## Request for Reimbursement Qualified Transportation Expenses

Employer: \_\_\_\_\_

Employee name (Please type or print): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employee address: \_\_\_\_\_ City State Zip Daytime Phone: \_\_\_\_\_

PLEASE CHECK IF THIS IS A NEW ADDRESS

### LIST EACH RECEIPT SEPARATELY

Person for Whom Expenses were Incurred (A)	Name and Address (including city and state) of Parking Facility or Mass Transit Authority (B)	Dates Service Provided (C)	Requested Amount of Reimbursement (D)	PIOPAC Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

### Provider's Certification/Verification

I certify that the employee named above incurred the above-described Parking and/or Mass Transit expenses.

Business/Provider Signature \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_

### HOW TO FILE A REQUEST FOR REIMBURSEMENT

1. Complete, date and sign this form. Failure to complete all areas can result in a delay in processing and claim reimbursement.
2. Attach third party receipts or bills showing items A, B, C and D. A receipt will be required to process your claim unless receipts are not provided in the ordinary course of business. **Expenses should be substantiated within 180 days after expense is paid as required by IRS. Receipts for dates of service beyond 180 days will be denied without a brief explanation of why claim is being substantiated after 180 days.**

Reason: \_\_\_\_\_

3. The provider (Parking Facility or Mass Transit Authority) may certify these expenses by signing the provider's certification.

### QUALIFIED TRANSPORTATION EXPENSES

To qualify for reimbursement, parking expenses must be incurred for parking at or near the business premises of your employer and be less than your election for the coverage period (and the applicable statutory limit of \$230 per month). Parking expenses also qualify for reimbursement if incurred for parking at or near a location from which you commute to work by mass transit (subway, bus, etc.), van-pooling, in a commuter highway vehicle, or by carpool. It does not include parking at or near an employee's residence.

Reimbursement of mass transit expenses will be allowable only if your employer determines that the administrative costs (imposed by the mass transit authority) associated with purchasing and distributing mass transit passes exceeds 1% of the value of such benefits. The expenses must also be less than your election for the coverage period and the applicable statutory limit (\$230 per month).

I request reimbursement and certify that these are eligible Transportation Expenses.

Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

FAX completed Request for Reimbursement forms to (808) 536-0430, Email to [FSAClaims@piopac.com](mailto:FSAClaims@piopac.com) or MAIL to:

PIOPAC Fidelity  
FSA Claims Dept.  
1132 Bishop Street Suite 2101  
Honolulu, HI 96813



**Employer Name:** \_\_\_\_\_

**FSA Salary Redirection Agreement**

Division: \_\_\_\_\_ Plan Year \_\_\_\_\_

Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

Eligibility Date: \_\_\_\_\_ Date of First deduction: \_\_\_\_\_

Status Change: \_\_\_\_\_ Effective Date: \_\_\_\_\_

I authorize my employer to deduct on a pre-tax basis for the applicable plans below for which I am participating:  
Complete the following elections if participating in a Medical or Dependent Care FSA Plan:

Medical FSA: \$ \_\_\_\_\_ per pay period X \_\_\_\_\_ no. of deductions = \$ \_\_\_\_\_ annual election

Dependent Care FSA: \$ \_\_\_\_\_ per pay period X \_\_\_\_\_ no. of deductions = \$ \_\_\_\_\_ annual election  
(\$5,000 maximum for married couple and \$2,500 maximum for single parent)

Transportation Benefit: \$ \_\_\_\_\_ per pay period X \_\_\_\_\_ no. of deductions = \$ \_\_\_\_\_ annual election  
(\$230 maximum for parking and \$120 maximum for mass transit)

Flex Premium: \$ \_\_\_\_\_ per pay period X \_\_\_\_\_ no. of deductions = \$ \_\_\_\_\_ annual election  
(Family portion of Group Medical and qualified Voluntary Products)

I understand and agree that by electing any of the above that (initial all):

Initial On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement **with respect to pre-tax premiums before the next anniversary date of the plan** unless a "change in family status" occurs (as defined under the Plan and Internal Revenue Code), and the change is caused by and consistent with the "change in status." **I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.**

Initial Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Dependent Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

Initial **FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANTS:** I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify my employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse my employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the plan year shall be retained by my employer and such amounts may (but are not required to) be used to offset administrative expenses or future costs, and that the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by my employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount. I acknowledge that in some cases reimbursement for eligible Medical and Dependent Care FSA expenses may be administered through an electronic payment card ("the Card") and agree to abide by the terms and conditions of the Plan with regard to such card usage and the electronic payment cardholder agreement, including any fees applicable to the Card, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. I also agree to use the Card exclusively for Medical and/or Dependent care FSA expenses and to retain paper documentation for any claims adjudicated by the Card.

**WAIVER OF PRE-TAX BENEFIT UNDER THE FLEXIBLE BENEFITS PLAN**

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. I elect to waive all pre-tax benefits under the plan, and understand that the benefits may be elected on an after-tax basis. Except for a change in family status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

Initial

Signature \_\_\_\_\_

Date \_\_\_\_\_



**EMPLOYEE ENROLLMENT/CHANGE FORM**

New Enrollment      Use FSA Salary Redirection Agreement Form for Flexible spending Election  
 Change Info  
 Termination  
 COBRA

PIOPAC USE ONLY:  
 NE Process Date \_\_\_\_\_       Term Process Date \_\_\_\_\_  
 CI Process Date \_\_\_\_\_       COBRA \_\_\_\_\_

Employer: \_\_\_\_\_ Division: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Employee: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status:  Single  Married

FOR FAMILY RX/VISION/DENTAL COVERAGE – FOR OPT OUT, ONLY SPOUSE INFO REQUIRED: Spouse will receive Flex Debit Card for HRA

	D.O.B.:	M/F:	SS#:
Spouse:			
Child:			
Child:			
Child:			
Child:			
Child:			

TO BE COMPLETED IF CHILD IS OVER 18 YRS OLD AND A FULL TIME STUDENT:

Student Name:

Authorization: I certify the above information is correct and true to the best of my knowledge. The children listed under "dependent coverage" resides with me or are my legal IRS dependents in a parent-child relationship.

Signature Required for Benefits: \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYER USE ONLY:**

Summerlin Medical:     RX    Vision    Dental    HRA

Annual HRA Contribution:    Single \$ \_\_\_\_\_    2-Party \$ \_\_\_\_\_    Family \$ \_\_\_\_\_

Kaiser Medical:             Dental Only    Single    2-party    Family

HMSA Medical               \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

Opt Out of Group Medical Benefits:    Annual HRA Amount: \$ \_\_\_\_\_



# Insurance Claim Form

**DENTAL**  **VISION**

**Participant name** (Please type or print): \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Participant Address** (complete only if new): \_\_\_\_\_  
 \_\_\_\_\_ City State Zip

**Employer** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

By submitting this claim form, I certify and warrant to PIOPAC Fidelity that these services I or my dependents have incurred.

=>**Participant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**LIST EACH CLAIM SEPARATELY**

Patient Name (A)	Provider Name (B)	Description of Service (C)	Dates of Service (D)	Claim Amount	PIOPAC Use Only

**TO SUBMIT YOUR COMPLETED FORM:**

**FAX** completed Insurance Claim form to: **(808) 536-0430**

*Note: Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to PIOPAC.*

**OR**

**MAIL** completed request for reimbursement forms to:

PIOPAC Fidelity  
 Claims Dept.  
 1132 Bishop Street, Suite 2101  
 Honolulu, HI 96813

**For Customer Service call: (808) 526-0097 ext. 233 or 242 or Toll Free – 800-777-0284**

**FOR OUT-OF-POCKET EXPENSE NOT COVERED BY PLAN, YOU MUST USE  
 THE REQUEST FOR REIMBURSEMENT FORM**

**Request for Taxpayer  
Identification Number and Certification**  
**PIOPAC FIDELITY**

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return) <b>PIONEER PACIFIC CORPORATION 1132 Bishop St., Suite 2101</b>	
	Business name, if different from above <b>Honolulu, Hawaii 96813</b>	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.) <b>PIOPAC FIDELITY</b>	Requester's name and address (optional)
	City, state, and ZIP code <b>1132 Bishop St., Suite 2101</b>	
List account number(s) here (optional) <b>Honolulu, Hawaii 96813</b>		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number <b>99-0331716</b>

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

**Part II Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶ <i>Alex Ma</i>	Date ▶ <i>1/3/2011</i>
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**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



**PIOPAC Fidelity**  
**Third Party Administration**  
 "Security, Integrity, Trust"

DEBIT FORM

*AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT (ACH DEBITS)*

Company Name \_\_\_\_\_ Company Federal ID \_\_\_\_\_

I hereby authorize **PIOPAC Fidelity**, hereinafter called **Company**, to initiate debit entries to our Checking Account indicated below at the depository financial institution named below, hereinafter called **Depository**, to debit the same to such account. I acknowledge that the origination of ACH transactions to our account must comply with the provisions of the U. S. law.

Depository Name \_\_\_\_\_ Branch \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name \_\_\_\_\_ Title \_\_\_\_\_  
 (Please Print)

Date \_\_\_\_\_ Signature \_\_\_\_\_

ACH Medical Debit \_\_\_\_ and \_\_\_\_ of every month for FSA and HRA Contributions

ACH Self-Fund Debit – 15<sup>th</sup> and EOM (end of month) for Dental/Vision/RX

Other \_\_\_\_\_

\_\_\_\_\_  
 Print Name/Signature

# Transit/Parking Plan Salary Redirection Agreement

<b>EMPLOYER:</b>	<b>GROUP NUMBER:</b>	<b>PLAN YEAR:</b> / / - / /
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**Payroll Mode:** ( ) Weekly ( ) Biweekly ( ) Semimonthly ( ) Monthly **Date of first deduction:** \_\_\_\_\_

I hereby enroll in my employer's Pre-tax Transportation Plan and elect to have my salary reduced (as noted below) to fund qualified transportation benefits. I understand that an amount equal to the total amount of my election will be withheld from my salary, therefore reducing my compensation by the amount of salary reduction I elect. This election will continue for each pay period until this agreement is amended or terminated for a future Coverage Period. In addition, I understand that pre-tax contributions reduce my compensation for Social Security tax purposes, and that my Social Security benefits therefore may be decreased. I elect to receive the amount listed below for qualified transportation expenses. Any previous election and Salary Reduction Agreement under the Transportation Plan is hereby revoked. My employer's deduction of contribution amounts hereunder shall evidence acceptance of this Agreement.

<b>Check one of the following and complete the election below:</b> <input type="checkbox"/> <b>New Election</b> <input type="checkbox"/> <b>Re-enrollment</b> <input type="checkbox"/> <b>*Change In Election</b>
---

Parking Expenses (\$ \_\_\_\_\_ per pay period) X ( \_\_\_\_\_ number of deductions) = \$ \_\_\_\_\_  
(not to exceed amount specified by regulations)

Mass Transit Expenses (\$ \_\_\_\_\_ per pay period) X ( \_\_\_\_\_ number of deductions) = \$ \_\_\_\_\_  
(not to exceed amount specified by regulations)

<b>I understand and agree that (initial all):</b>
---

INITIAL My election of benefits under the Transportation Plan can only be changed as of the beginning of the next Coverage Period in accordance with the Employer's Plan Document and that any election change will not be effective until the first pay check in the Coverage Period after the Change is processed by my employer. In addition, I understand that I have 180 days from date on receipt to get reimbursed for any qualified expenses under this plan.

INITIAL Elections under the Transportation Plan reduce my taxable compensation for Social Security tax purposes. This may result in a corresponding reduction in Social Security benefits.

INITIAL I verify that I have received a copy of the summary plan description, which describes the operational guidelines, and reimbursement procedures for use hereunder. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify my employer if I receive reimbursement for an expense that does not qualify.

INITIAL In addition to and without limiting in any way any rights my employer, the Plan, PIOPAC and their respective agents, employees, subcontractors and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status and transit benefit information) to the extent they deem reasonably necessary to administer the Plan (including evaluating and processing requests for payment of claims). I further authorize my employer, the Plan, PIOPAC and their respective agents, employees, subcontractors and assigns to further disclose any such personal information in any manner deemed necessary in furtherance of such purpose. I hereby waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration.

<b>Waiver of Pre-Tax Benefits Under The Transportation Plan:</b>
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INITIAL I certify that the features and benefits under the Transportation Plan have been explained to me completely. I elect to waive all pre-tax benefits under the plan.

<b>Signatures:</b>
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Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\*Employer signature is required for mid-year changes.*