FURTHER℠

PLAN CHANGES FORM

Please use this section to indicate any changes you wish to make to your plan for the upcoming year.

Group Information

Group Name: ______________________________ Further Group Number: ______________________________

Medical FSA

Plan Effective Date	Start Date _____-_____-_______		End Date _____-_____-_______
Minimum / Maximum Contribution Limits	Minimum $ ________________________		Maximum $ ________________________ *(IRS Maximum is $2,750)*
	Does the employer contribute to any account? ☐ Yes ☐ No		

Note: According to IRS FSA regulations, employers can contribute up to $500 to each employee without contributions from the employee. If the employer contributes more than $500, the employee must contribute. The employer contribution cannot exceed the amount contributed by the employee.

Grace Period	☐ Yes ☐ No	**Grace Period End Date**	_____-_____-_______
Runout Period	☐ Yes ☐ No	**Runout Period Length**	___________ months
Account Rollover	☐ Yes *Balance up to $550 rolls over to subsequent plan year* ☐ No *No balance rolls over*		
Reimbursement Options	Please contact Further directly to adjust Crossover or Debit Card elections.		

Dependent Care FSA

Plan Effective Date	Start Date _____-_____-_______		End Date _____-_____-_______
Minimum / Maximum Contribution Limits	Minimum $ ________________________		Maximum $ ________________________ *(IRS Maximum is $5,000)*
	Does the employer contribute to any account? ☐ Yes ☐ No		
Grace Period	☐ Yes ☐ No	**Grace Period End Date**	_____-_____-_______
Runout Period	☐ Yes ☐ No	**Runout Period Length**	___________ months

Health Savings Account			
Plan Effective Date	Start Date _____-_____-______	End Date _____-_____-_______	
HSA Plan Type Option	Further Premium HSA ☐	Further Select HSA ☐	Further Value HSA ☐
Participant Fees	Employer Paid ☐	Employee Paid ☐	
Reimbursement Options	Please contact Further directly to adjust Crossover or Debit Card elections.		

Health Reimbursement Account		
Plan Effective Date	Start Date _____-_____-_______	End Date _____-_____-_______
HRA Plan Type Option	☐ ER Pays First	Annual Funding Amounts $ _____________ Employee $ _____________ Employee & Child $ _____________ Employee & Spouse $ _____________ Employee & Children $ _____________ Family
	☐ Shared Payment Reimbursement Level ☐ 80% of eligible charges ☐ 50% of eligible charges ☐ Other ____________________	Annual Funding Amounts $ _____________ Employee $ _____________ Employee & Child $ _____________ Employee & Spouse $ _____________ Employee & Children $ _____________ Family
	☐ EE Pays First	Annual Funding Amounts for EE Pay First $ _____________ Employee $ _____________ Employee & Child $ _____________ Employee & Spouse $ _____________ Employee & Children $ _____________ Family Annual Threshold Amounts for EE Pay First $ _____________ Employee $ _____________ Employee & Child $ _____________ Employee & Spouse $ _____________ Employee & Children $ _____________ Family

Health Reimbursement Account (continued)		
Mid-Year Enrollees / Contract Changes	☐ 100% Funding regardless date of enrollment.	
	☐ Funding is prorated in monthly increments back to first of the month of enrollment	
	☐ Funding is a specific amount if enrollment occurs in final 6 months of plan year	Annual Funding Amounts $ ____________ Employee $ ____________ Employee & Child $ ____________ Employee & Spouse $ ____________ Employee & Children $ ____________ Family
Account Balance Cap	Balance Cap Limit: $ ____________ Employee $ ____________ Employee & Child $ ____________ Employee & Spouse $ ____________ Employee & Children $ ____________ Family	
Runout Period	☐ Yes ☐ No **Runout Period Length**	____________ months
Account Rollover	☐ Full Rollover	
	☐ Flat Dollar Limit	Rollover Limit: $ ____________ Employee $ ____________ Employee & Child $ ____________ Employee & Spouse $ ____________ Employee & Children $ ____________ Family
	☐ Percentage Rollover	____________ %
	☐ No Rollover	
Reimbursement Options	Please contact Further directly to adjust Crossover or Debit Card elections.	

Signature
Signature: ____ Date: ______________