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: _____