axis health partners

ENROLLMENT APPLICATION

EMPLOYER NAME		(PLEASE PRINT)

EMPLOYEE INFORMATION

			FOR ADMINISTRATIVE USE ONLY
SSN			**EFFECTIVE DATE**
Last Name		First Name	MI
Address			Date of Hire
City	State	Zip Code	DOB
Home Phone #			☐ Male ☐ Female
Work Phone #			☐ Single ☐ Married
Email			

FAMILY INFORMATION

(PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS TO BE ENROLLED.)

Spouse	DOB	SSN
Child	DOB	SSN
Child	DOB	SSN
Child	DOB	SSN
Child	DOB	SSN
Child	DOB	SSN

I acknowledge and agree to the following:

1. **ACCEPT PLAN TERMS:** I agree to abide by the terms, conditions and provisions of the Plan contained in the Summary Plan Description (SPD).
2. **RESPONSIBILITY:** I acknowledge that the Internal Revenue Code and the Plan permit me to claim reimbursement only for my tax deductible expenses incurred after the effective date of the Plan and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursement from the Plan for disallowed expenses.
3. **PLAN MODIFICATION:** I have been informed that the Plan offered by my Employer may be modified from time to time and I agree that my Employer may cancel or amend the Plan according to their independent judgment and discretion without my consent or prior notice to me.
4. **IRREVOCABLE ELECTION:** I understand that I cannot change or revoke my election until the open enrollment period for the new Plan Year unless I have a change in status as outlined in the Summary Plan Description (SPD). The election change must be requested within thirty-one (31) days of the event and must be due to and consistent with the change in status.
5. **CLAIM SUBSTANTIATION:** I understand and agree that all claims need to be substantiated. To satisfy the substantiation process I will keep all itemized receipts for claims paid using my debit card.
6. **DEBIT CARD USAGE:** I understand and agree that all debit card usages will be substantiated. If a debit card usage is found to be ineligible I understand and agree that I am responsible for reimbursing my account for the amount of the unsubstantiated card usage. **(Refer to the Summary Plan Description for a detailed explanation of claim and card substantiation.)**
7. **PARTICIPANT AUTHORIZATION:** I hereby authorize Axis Health Partners to request documentation on behalf of myself and my dependents, from merchants and providers paid using my AXIS MasterCard® Debit Card or Flexible Spending Account funds.

______________________________ ______________________________
Participant Signature Date