INSURANCE SAVINGS GROUP

MEMBER ENROLLMENT

1	Full Name		2	SSN	
3	Email Address				
4	Address				
5	City & State		6	Zip	
7	Date of Birth		8	Phone Number	
9	Employer				

HEALTH PLAN ELECTIONS

	Contributions Per Pay Period	Number of Pay Periods		Your Annual Election Amount
Health Care Flexible Spending Account	$	X	=	$
Dependent Care Account	$	X	=	$

☐ I hereby elect to participate in the Health Reimbursement Arrangement (HRA) plan.
☐ I have been offered the opportunity to enroll in my employer's health plan and do not wish to participate at this time.

SAVINGS GROUP MEMBERSHIP

☐ **$3,000** *savings limit*
$75 monthly savings contribution
Pays you 2% interest

☐ **$6,000** *savings limit*
$150 monthly savings contribution
Pays you 3% interest

☐ **$12,000** *savings limit*
$300 monthly savings contribution
Pays you 4% interest

BENEFICIARIES MUST BE 18 YEARS OR OLDER

Primary #1	Name			
	Phone Number		Relationship	
Contingent #2	Name			
	Phone Number		Relationship	

BANK INFORMATION

☐ I authorize ISG Administrators to initiate a credit and/or debit entry to my account for my health plan and savings group reimbursements. This agreement is to remain in full effect until written notification is supplied by me to ISG Administrators terminating this agreement.

A "VOIDED" CHECK MUST ACCOMPANY THIS FORM

Signature_____ Date _____ **PLEASE REVIEW AND SIGN BACK ▸**

HIPAA RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize ISG and my employer, their affiliates, employees, and agents (collectively my group health plan) to have access and to maintain my personal health information for the purpose administering my group health plan. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may be no longer protected by applicable federal and state privacy laws. This authorization is valid for the duration of the plan year, specified in my group health plan document and summary plan description. I understand that I have the right to revoke this by providing written notice to my employer or ISG. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My revocation or refusal of this release will affect my eligibility, enrollment, and benefits in my group health plan.

PAYROLL DEDUCTION AUTHORIZATION AND CERTIFICATION

I understand for my FSA/DCFSA that:

- **A** I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- **B** I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- **C** I must report any administrative errors to my payroll administrator or human resource department within 10 days of my first payroll of my first payroll deduction of the plan year.
- **D** Funds left in my dependent care account at the close of the plan year will be forfeited. Funds left in my Flexible Spending account may be forfeited, per plan rules. See plan documents for more details.

I will receive an ISG benefits card to access funds in my account. I certify that:

- **E** The card will be used for eligible medical and/or dependent care expenses.
- **F** Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care accounts.
- **G** If I violate these rules I acknowledge that I must repay my group health plan. I further authorize ISG to initiate an ACH bank transaction from my account to the group health plan for reimbursement.

Signature_____ Date _____