McLaren HEALTH ADVANTAGE

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM
PLAN YEAR 2026

Please PRINT Clearly

Section 1: Personal Information

Group/Employer

☐ BAY 700 ☐ MHP 450 ☐ CENTRAL 360 ☐ CARO 510	☐ MMG 200 ☐ LANSING 600 ☐ FLINT 100 ☐ THUMB 530	☐ LAPEER 500 ☐ NORTHERN 410 ☐ MACOMB 750 ☐ LAKE ORION 330	☐ OAKLAND 770 ☐ MHCC 400 ☐ MHG 280 ☐ MCLAREN HOSP GRP 790	☐ KARMANOS 460 ☐ PORT HURON 480 ☐ MARWOOD 485

Employee First Name	Middle Initial	Last Name	SSN

Employee's Home Address Street	City	State	Zip

Employee's Email Address	Home Phone	Cell Phone	

				Employer Use Only:	
Date of Birth	Gender	Status	Date of Employment	Date of 1st Deduction	Effective Date for Plan
	☐ Male ☐ Female	☐ Single ☐ Married			

Section 2: Payroll Deduction Information

I authorize the following amounts to be deducted pre-tax from each paycheck ($130.00 minimum per year deferral).

Plan Year Total

Health Care Reimbursement:
Plan Year Total cannot exceed $3,300 _____

Dependent Care Reimbursement:
Plan Year Total cannot exceed $7,500
Dependent Children Under 13 years of age _____

Totals _____

Section 3: Acknowledgements and Authorization

You must agree to the following terms by signing below to participate in the FSA Program.

1. You will only be reimbursed for expenses incurred during the plan year.
2. You must not submit a claim for reimbursement for expenses covered by any other source, such as insurance.
3. You must provide proper documentation in order to receive reimbursement.
4. You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes. Please see the Summary Plan Description.
5. You must assume full responsibility for any expenses paid for on your MBI Debit Card and the substantiation of any such purchases upon request by Health Advantage or the IRS.
6. You will only submit a claim for reimbursement for purchases paid for by cash, personal check or personal credit card. You will not submit a request for reimbursement for purchases made on your Benefits Card.

_____ _____

Employee Signature Date

Rev 10/2025