HealthEquity®

NEW YORK STATE | Flex Spending Account

NEW YORK STATE
ADOPTION ADVANTAGE ACCOUNT ENROLLMENT FORM

January 1 – December 31

ENROLLMENT INFORMATION

Employee Name

Mailing Address

City, State, Zip

Email Address | Phone

NYS Employee ID | Date of Birth (MM/DD)

Department ID | Bargaining Unit Number

Change in status event date

Reason for change: ☐ New hire ☐ Beginning adoption proceedings ☐ Return from leave of absence

☐ I hereby elect to participate in the Adoption Advantage Account

Annual Election: $ _____ Accelerated Payroll End Date: _____

☐ Stop my participation due to the termination of adoption proceeding.

Administrative Use Only	**Per Pay Period**	**# Pay Periods**	**Annual Election**
Adoption Advantage Account	$ _____	X _____	= $ _____

Effective date of coverage: _____ The first payroll deduction will be on: _____, 20_____

Date of hire: _____ Pay schedule is: ☐ Institution ☐ Administration

AUTHORIZATION & ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects me or my dependents' eligibility under this Plan or another employer plan and includes the commencement or termination of adoption proceedings. The rules regarding election changes are described in more detail in the Summary Plan Description.

By participating in the NYS Adoption Advantage Account, I understand that I am authorizing The State of New York to take payroll deductions to cover the amount of my annual election.

I understand that I must submit a claim and appropriate documentation (e.g. itemized bill) for out-of-pocket adoption expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Adoption Advantage Account for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Adoption Advantage Account. I certify that I will not submit claims for reimbursement under the Adoption Advantage Account for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Employee Signature | Date

HealthEquity is the administrator of your Plan.

Please return this form via fax
518-473-3581.