

Employee Flexible Benefits Plan Election Form



Please check one of the following:

- Open Enrollment for New Plan Year (Plan Year: _____)
- New Employee (Plan Year: _____)
- Change of Contribution / Payroll Deduction
Event / Reason for Change: _____
Date of first paycheck affected: _____

SHADED AREA TO BE COMPLETED BY EMPLOYER

| Group Number | Location | Employee Classification | Effective Date |
|--------------|----------|-------------------------|----------------|
| | | | |

(Indicate New Annual Election and per Paycheck Contribution Amount in Section 2)

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|----------------------|---|---|--|
| 1. | Last Name First Name Middle Initial | Date of Birth Month Day Year | Sex Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Employee Information | Mailing Address | Social Security Number | |
| | City State Zip | Marital Status Married <input type="checkbox"/> Unmarried <input type="checkbox"/> | Date Employed / / |
| | Employer Name | Home Telephone No. () | |

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|-----------------------------------|--|---|--|
| 2. | I elect to allocate the following on a monthly basis: Medical Reimbursement Plan | [] X [] = [] Monthly Before-Tax Dollars # of Months (i.e. 12) Annual Before-Tax Dollars | |
| Medical Reimbursement Plan | Payroll Deductions [] Total Annual Before-Tax Dollars | ÷ [] = [] # of Payroll Periods Contribution per Paycheck | |
| | This is a change. New annual election \$ _____ New per paycheck contribution \$ _____ | | |

| | | | |
|--|---|---|--|
| 3. | I elect to allocate the following on a monthly basis: Dependent Care Reimbursement Plan | [] X [] = [] Monthly Before-Tax Dollars # of Months (e.g. 12) Annual Before-Tax Dollars | |
| Dependent Care Reimbursement Plan | Payroll Deductions [] Total Annual Before-Tax Dollars | ÷ [] = [] # of Payroll Periods Contribution per paycheck | |
| | This is a change. New annual election \$ _____ New per paycheck contribution \$ _____ | | |

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|-----------------------------|--|
| 4. | I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible spending account should be made payable to the undersigned. Relationship _____ Beneficiary _____ |
| Designate your beneficiary. | |

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|---|---|
| 5. | I have been given the opportunity to participate in the above Medical and Dependent Care Reimbursement Plans and have elected not to do so. Signature _____ Date _____ |
| Sign ONLY if you decline to participate in the Medical and Dependent Care Reimbursement Plans. | |

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|--------------------------|--|
| 6. | Group sponsored insurance premiums may be funded with pre-tax dollars. I authorize my employer to reduce my salary by the employee contribution amount, as designated by my employer to cover the premium for my employer sponsored insurance plans in which I have elected to enroll. Signature _____ Date _____ |
| Premium Only Plan | |

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|----------------|--|
| 7. | My signature on this form certifies that I have received and read the printed material explaining my employer's flexible spending program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (i.e., marriage, divorce, birth or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above. Signature _____ Date _____ |
| Read and sign. | |