FLEXIBLE BENEFITS PLAN ELECTION FORM & COMPENSATION REDIRECTION AGREEMENT

Company:

⏩ ALL FIELDS ARE REQUIRED – PLEASE PRINT ⏪

PLAN YEAR DATES: **To**

DIVISION: _____**(if applicable) DOH**_____ **EFF DATE**_____

SOCIAL SECURITY NUMBER: _____

FULL NAME: _____

HOME ADDRESS: Street _____

City _____ **State** _____ **Zip Code** _____

EMAIL ADDRESS: _____

DATE OF BIRTH:_____ **HOME PHONE:** _____

ELECTION OF BENEFITS

In accordance with my rights under the Plan, I elect the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the Plan Year designated above.

⏩ **I receive my paychecks:**

☐ **Weekly**(52) ☐ **Biweekly**(26) ☐ **Biweekly**(24) ☐ **Semimonthly**(24) ☐ **Monthly**(12)

FLEXIBLE SPENDING ACCOUNT OPTIONS	PAY PERIOD ELECTION AMOUNT (Plan Year Amt ÷ # Pay Periods)	PLAN YEAR ELECTION AMOUNT (Pay Period Amt x # Pay Periods)
1. Health Care Reimbursement Arrangement *(maximum $ 3300 per plan year)*		
a.) Traditional Health Care FSA	$_____	$_____
b.) Limited Purpose Health Care FSA (if have HSA)	$_____	$_____
2. Dependent/Child Care Reimbursement Account *(maximum $ 5000 per tax year)*	$_____	$_____

After completing your election above, **read the back of this form carefully**. Please **sign and date** the reverse side of this form **if you want to participate** in any of the **spending arrangement options above.**

EMPLOYER USE ONLY – PLEASE COMPLETE BEFORE SENDING COPY TO ADMIN AMERICA

FIRST DEDUCTION/PAY DATE: _____ **TOTAL NUMBER OF DEDUCTIONS:** _____

HEALTH CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying health care expenses**" as described in the **Summary Plan Description.**
- **I cannot change or revoke my Health Care Reimbursement Arrangement at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description**.
- **If either my spouse or I participate in an HSA then I am not eligible to participate in the Traditional Health Care FSA offered by my company**. However, I may sign up for the **Limited Purpose FSA offered by my company for vision and dental expenses only**.

DEPENDENT CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying dependent care expenses**" as described in the **Summary Plan Description**.
- **I cannot change or revoke my Dependent Care Reimbursement Arrangement at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description**.

OTHER IMPORTANT TERMS AND CONDITIONS

I understand that:

- Before the first day of each plan year I will be offered the opportunity to make my benefit election for the new year**. If I do NOT complete and return a new election form prior to the first day of the new year**, I will be treated as having elected NOT to participate in reimbursement arrangements effective for the new plan year.
- **I am solely responsible for notifying the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense**. I also agree to indemnify and reimburse the Employer on demand for any liability it incurs for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive for a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it is required in order to satisfy federal law.
- **Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year. Plans that offer the rollover provision are subject to the aforementioned forfeiture for account balances over the rollover limit. See your plan documents for additional details. Plans that offer the grace extension allow dates of service after the plan year end up to the final grace date. See your plan documents for additional details.**
- My Social Security benefits may be slightly reduced as a result of my election.

This agreement (1) is subject to the terms of the employer's Flexible Benefits Plan, Health Care Reimbursement Plan and/or Dependent Care Assistance Plan in effect as amended from time to time, (2) shall be governed by and construed in accordance with applicable laws, (3) shall take effect as a sealed instrument under applicable laws, and (4) to the extent allowed by law, revokes any prior election and compensation redirection agreement relating to such plan(s) for the corresponding Plan Year.

Employee's Signature: _____ **Date:** _____

Accepted and agreed to by the Employer's Authorized Representative:

By: _____ **Date:** _____