Flexible Benefit Plan Election/Change Form

Company/School district: _____

1. Employee information

_____ _____ _____ _____
Last name First MI Social Security number

_____ _____ _____ _____
Mailing address (required for FSA participants) City State Zip code

2. Enrollment activity:

New enrollment (go to step 3)

Change to existing account (go to step 4)

3. Enrollment information (required) Check one: Annual enrollment New employee

Effective date: _____ Number of annual deductions _____

Spouse's name (if also an employee of this company/school district) _____

Maximum annual deduction for all Flexible Benefits: $ _____ (*)

From amount in line above (*), indicate maximum allowable for unreimbursed medical expenses: $ _____

4. Change information Effective date: _____

Reason for change (check one):
_____ Birth or adoption of child
_____ Death of child or spouse
_____ Marriage or divorce
_____ Spouse employment change
_____ Change of employment status

5. Benefit election:

For items 1–9, please check **one** of the boxes in the three columns.	Pre-tax salary deduction	After-tax salary deduction	Cancel benefit
1. Medical	☐	☐	☐
2. Basic life*	☐	☐	☐
3. Supplemental life*	☐	☐	☐
4. Disability income**	☐	☐	☐
5. Dental	☐ n/a	☐	☐
6. Vision	☐	☐	☐
7. Hospital indemnity	☐	☐	☐
8. Cancer/dread disease	☐	☐	☐
9. Other _____	☐	☐	☐
Medical reimbursement (per pay)***	$_____	**Check to decline this option** _____	
Dependent care reimbursement (per pay)***	$_____	**Check to decline this option** _____	
Total elected deduction amount	$_____ (per pay) ***or*** $_____ (annual)		

Please omit dependent care deductions for the months of: _____ _____ _____.

Note: *Only the first $50,000 of group term life is excludable from income under Section 79 of the Internal Revenue Code.
**Disability Benefits purchased with pre-tax dollars will be taxable and subject to FICA for first six months.
***FSA PARTICIPANTS MUST COMPLETE A NEW ELECTION FORM EACH YEAR.

By signing this form, I understand that completion of this form does not guarantee coverage under the selected benefits. A separate application/enrollment form must be completed and evaluated by the insurance carrier for the benefit(s) that I have selected under the Flexible Benefit Plan. I authorize my employer to deduct from my paycheck the deductions indicated above. I understand that these elections are irrevocable for the plan year commencing on _____ and ending on _____ unless I have a qualifying circumstance in accordance with Internal Revenue Code Section 125 and must notify my employer to change my benefit(s) within the time specified by my employer.

Employee signature: _____ Date: _____

I acknowledge that I have been given the opportunity to participate in the benefits offered by my employer under the Flexible Benefit Plan and decided not to enroll in any benefits offered under the Flexible Benefits Plan. I understand that I will not be able to participate in the Flexible Benefit Plan until the enrollment period for the next plan year unless I have a qualifying circumstance in accordance with Internal Revenue Code Section 125.

Employee signature: _____ Date: _____

Forward Signed Form To Your Benefits Administrator