Educators Benefit Consultants, LLC
Third Party Administrator

3125 Airport Parkway, Cambridge, MN 55008
Metro: 763-552-6053 Toll Free: 888-507-6053 Fax: 763-552-6055
www.ebcsolutions.com

Section 125 Plan – Benefit Election Form

For Plan Year Ending: _____ Employer: _____

Name: _____ SSN: _____

Address: _____

Email Address: _____

I elect to receive the following benefits (in addition to payroll-deducted insurances) in accordance with, and subject to the provision of the plan in the amounts stated below:

Dependent Care*.....$_____

Group-Term Life Insurance* (on employee's life only) .....$_____

Outside Health Insurance Premiums.....$_____

Health FSA **(This category has an election limit of $2,600**)** .....$_____
(Out-of-pocket medical, dental, vision, co-pay, deductibles, over-the-counter items, etc.)
(If you elect in this category, you cannot fund an HSA!)

Total Elections (may not exceed $20,000) .....$_____

*Please refer to limitations stated in the Flexible Spending Plan Employee Worksheet or Summary Plan Description.
** New election limit imposed by Health Care Reform.

1. **Pay Reductions**. I elect to reduce my pay at such times as set out in the Plan by the amount noted above.
2. **Understandings**. I understand my election in each category (including payroll deducted insurance) may not be dropped or changed for the plan year unless I submit an Election Change Form and meet the requirements for changing my election. I understand I may not "shift" amounts from one category to another, and that if I do not incur expenses of at least the amount of my election during the plan year in each of the categories, I will forfeit the unused amount. I understand my election may be reduced under the terms of the plan if I am a "highly compensated employee" under certain circumstances.
3. **Elections**. I understand I am authorizing the deductions of the above expenses from my salary pre-tax.

_____ _____
Signature Date

This form must be submitted to the employer prior to the first day of the plan year