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MESSA
Good health. Good business. Great schools.

MESSA OptionALL

Medical / Dependent Care Flexible Spending Account

ELECTION AND SALARY REDUCTION AGREEMENT FORM

Employee name _____
First *Middle* *Last*

Address _____
Street *Apt. / lot #*

_____
City *State* *Zip code*

Social security number _____ Gender ☐ male ☐ female

Job title _____ Date of birth _____

School district where you're employed _____

Daytime telephone number _____

BENEFIT ELECTION

I am electing the following benefits:

ANNUAL EMPLOYEE CONTRIBUTION

_____ Dependent Care Reimbursement Plan $ _____

_____ Medical Reimbursement Plan $ _____

Number of pay periods _____ First payroll deduction date _____

DEPENDENT INFORMATION

First name	Middle initial	Last name	Social Security #	Relationship	Date of birth	Sex	F/T Student

I understand that this election will remain in effect in accordance with the rules and procedures of the MESSA OptionALL plan. I MUST complete a new Benefit Election form each plan year.

_____ _____
Employee signature Date