Aviben
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1995 E. Rum River Dr. S., Cambridge, MN 55008
Metro: 763-552-6053 | Toll Free: 888-507-6053
Fax: 763-552-6055 | www.aviben.com
A Division of Educators Benefit Consultants, LLC ("EBC")

Section 125 Plan – Benefit Election Form

For Plan Year Ending: _____ **Employer:** _____

Name: _____ **SSN:** _____

Address: _____ **DOB:** _____

Email Address: _____ **Hire Date:** _____

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	$_____

Total elections in the following two categories can not exceed $2,750

Full-Use Health FSA (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!)	$_____
Limited-Use Health FSA (To be used with HSA--out-of-pocket vision and dental only)	$_____
Total Elections (may not exceed $20,000 for the categories listed above	**$_____**
Health Savings Account (HSA)	$_____

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

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