Election Form

– If not electing for the current year, please fill in name at top and sign at the very bottom to waive participation –

Employer Name (Please Print) _____ Payroll Effective Date _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

I hereby authorize and direct my employer to reduce my earnings in the amount necessary to fund my Cafeteria Plan as indicated below. I understand such reductions, considered elective contributions under the Plan, will start with my first paycheck dated after the plan year begins. I understand that the purpose of this program is to allow employees to select qualified benefits within the guidelines of the Internal Revenue Code. I also understand that the flexible spending account plan(s) will allow me to be reimbursed for eligible out-of-pocket medical, dental, vision and/or dependent care expenses.

☐ I choose to participate in Flexible Spending Account (FSA) elections.

Health FSA – Medical Expenses ..... $ _____ (Annual Amt.)

DCAP – Dependent Care (Child Care) Expenses..... $ _____ (Annual Amt.)

Limited FSA – Dental/Vision Only Expenses..... $ _____ (Annual Amt.)

☐ I choose the debit card for my payment method.

I understand that the debit card is restricted to certain merchant categories and is not accepted at all Mastercard® acceptance locations. I understand that I may not obtain a cash advance with the debit card at any merchant, bank or ATM. I understand that the debit card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the debit card is issued pursuant to Employer Plans and I use the Card for an expense that is not a Qualified Expense I am indebted to my Employer and must repay the full amount of the non-qualified expense. I agree to save all invoices and receipts related to any expenses paid with the debit card; upon request I must submit these documents for review by my benefits administrator. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and I will be required to remit payment to my Employer. Payment may be in the form of an offsetting claim, personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.

Additional Card Requested: Name on 2nd Card (cannot be same as Employee) _____

☐ I choose Direct Deposit for my payment method.

Routing Transit Number
(All 9 boxes must be filled)

☐☐☐☐☐☐☐☐☐

Account Number
(Include hyphens, but not spaces or special symbols)

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ATTACH A VOIDED CHECK HERE

DO NOT attach a Deposit Slip because deposit slips often do not show all the needed information

I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in my family status. I hereby certify the above information to be correct and true and I choose to participate.

Signature _____ Date _____

OR I choose not to participate in the FSA for this plan year (sign bottom line).

Signature _____ Date _____

Beneliance
Toll-free: 877-685-0655 | Fax: 501-553-9097
PO Box 55068, Little Rock, AR 72215 | beneliance.com