Sec. 125 Cafeteria Plan Premium Reduction Option *Plus* FSAs
Benefit Election Form and Salary Reduction Agreement

EMPLOYER NAME: _____

(PLEASE PRINT CLEARLY)

Employee Name (Last, First, MI) Social Security No.

Employee Street Address City, State, Zip Code

First Paycheck Effective Date **Pay Schedule (Weekly, Bi-weekly, Bi-monthly)**

Employee E-Mail Address _____

I hereby authorize and direct my employer to reduce my salary in the amount for Reimbursement Accounts headings shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date the Plan. Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction. (**THE MEDICAL FLEX MAXIMUM AN EMPLOYEE CAN DEDUCT IS NOW $3300 UNLESS YOUR EMPLOYER HAS A LOWER MAXIMUM. THE DEPENDENT CARE MAXIMUM IS $5000.00 PER FAMILY IF FILING JOINT OR SINGLE - $2500 IF MARRIED BUT FILING SINGLE)**

Reimbursement Accounts	**Employee**	
FSA Medical Expenses	$_____ per pay	$_____ Annually
FSA Dependent Care	$_____ per pay	$_____ Annually

I have read or will read the Summary Plan Description with the Plan Information Summary given to me by my Employer. This election form 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 family status as listed on the Status Change Matrix I will receive with the Summary Plan Description.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**

Signature_____ Date_____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**

Signature_____ Date_____

PLEASE REIMBURSE ME BY DIRECT DEPOSIT WHEN AVAILABLE USING THE ACCOUNT BELOW

SIGNATURE _____

New Personal Bank Account Information **(Please print) EFT REIMBURSEMENT (Direct Deposit)**			
Account Holders Name:			
Bank Name:			
Address:	**City:**	**State:**	**Zip:**
Routing Number: **☐ Checking or ☐ Savings**		**Account Number:**	

newemployee