Section 125 Election Form

Employee Information

Employer		Pay Frequency	Choose	Payroll Effective Date	
Last Name		First Name		MI	
Address 1		Address 2			
City		State		Zip	
Email Address					
DOB		SSN		Primary Phone	

Dependent Information

Name		Relationship		DOB		SSN	
Name		Relationship		DOB		SSN	
Name		Relationship		DOB		SSN	
Name		Relationship		DOB		SSN	
Name		Relationship		DOB		SSN	
Name		Relationship		DOB		SSN	

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.

Elections

Healthcare FSA *(Medical, Dental, Vision expenses)*	$ Per Pay		$ Annually	
Dependent Care FSA *(Childcare expenses)*	$ Per Pay		$ Annually	
☐ By checking this box, I choose to waive coverage				

Debit Card Agreement

☐ By checking this box, I choose a 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.

☐ By checking this box, I am requesting an additional card	Name on 2nd Card	

Direct Deposit Agreement

☐ By checking this box, I choose direct deposit for my payment method		Bank Name	
Routing Transit Number		Bank Account Number	

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	