Business Solutions
Business Simplified

Flexible Benefit Plan Election Form and Contribution Agreement

1. Employee Information — Please Print Clearly — Refer to Back for Instructions

Full Name: _____ **Social Security Number:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Cell Phone Number:** _____

E-Mail: _____ **Date of Birth:** _____

(CGI will only use the provided e-mail address and telephone # for the sole purpose of issuing correspondence regarding your account, not for solicitation purposes)

Plan Year Beginning/Date of Eligibility: _____

2. Election Agreement for Insurance Premium Pre-Tax Deductions

☐ Yes, I have elected insurance coverage and authorize contributions in the amounts of current premiums deducted from my paycheck pre-tax
I understand that:

____ If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my Contributions will automatically be adjusted to reflect that increase or decrease.

____ Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit election for the following Plan Year.

☐ No, I hereby waive this benefit.

3. Flexible Spending Benefit Plan Pre-Tax Elections

Health Care Spending Account **Reimbursement will only be available for "qualifying medical care expenses" for my eligible dependents and/or myself during the Plan Year as described in my Summary Plan Description and Employee Booklet. You will need to read the Flexible Benefit Plan Terms and Conditions on the back of this form.** **Effective January 1, 2020 The Cares Act treats all OTC drugs, medicines and now menstrual care products as qualifying medical expenses that may be paid for (or reimbursed) on a tax-free basis by a Health FSA. This change eliminates the ACA Provision that requires individuals to have a prescription for an OTC medicine, except insulin.**

☐ **Yes, I elect to participate in the Health Care Spending Account.**

$ _____ X _____ = $ _____

Contribution per pay period | # of pay periods in plan year | Total Annual Election*

The FSA Plan Limit for the 2026 calendar year is $3,400.00

with a minimum of $25.00

☐ **No, I hereby waive this benefit.**

4. Dependent Care Spending Benefit Plan Pre-Tax Elections

Dependent Care Spending Account **Reimbursement will only be for care for children under age 13 that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves. An Eligible Care expense must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after-school, summer day camp, or by a nanny in your home.**

☐ **Yes, I elect to participate in the Dependent Care Spending Account.**

$ _____ X _____ = $ _____

Contribution per pay period | # of pay periods in plan year | Total Annual Election*

The DCA Plan Limit for the 2026 calendar year is $7,500.00

with a minimum of $25.00

☐ **No, I hereby waive this benefit.**

5. Direct Deposit Application

To receive reimbursements for out-of-pocket medical and/or dependent care expenses as a direct deposit to your personal checking or savings account (rather than receiving paper checks) please complete the below section and attach a voided check or savings deposit slip.

Name of Bank:	☐ **Checking Account**	☐ **Savings Account**
(ABA) Routing #: 9 Digits located on the bottom left hand side of check	**Account #:** located after ABA # (Do not include check #)	
☐☐☐☐☐☐☐☐☐	_____	

6. Signatures By signing below, I agree to all of the FSA Plan Terms and Conditions on the back of this form.

Employee Signature (required):	**Date:**
Employer Signature (required):	**Date:**