

## ELECTION FORM and SALARY REDUCTION AGREEMENT FLEXIBLE BENEFITS PLAN

Please print clearly

Plan Year: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Name: \_\_\_\_\_  

First
Last

Mailing Address: \_\_\_\_\_  

City
State
Zip

Email Address: \_\_\_\_\_

SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pursuant to my Employer's Flexible Benefits Plan ("Plan"), I understand I may elect to have my salary reduced by the total pre-tax specified below. I authorize my Employer to apply that amount toward any or all of the following Plan Components:

- Premium Reimbursement Component, under which I can pay for my share of individual Insurance policy premiums with pre-tax dollars;
- Non-Reimbursed Medical Spending Account, under which I can elect coverage that will reimburse me for my eligible Medical Care Expenses, up to an annual limit as designated by the Plan, and
- Dependent Daycare Spending Account, under which I may elect coverage that will reimburse me for my eligible Dependent Daycare Expenses, up to an annual limit of \$5,000 (\$2,500 if married and filing separate tax returns)

### ELECTION OF PRE-TAX BENEFITS UNDER THE SALARY REDUCTION PLAN

*I elect to receive the following coverages under the Plan. I understand an amount equal to the annual premiums, divided by the number of pay periods in the Plan Year, will be deducted from each of my paychecks to pay for the coverages that I elect.*

**PREMIUM REIMBURSEMENT (Individual Policies)**

\$ \_\_\_\_\_ per pay period X \_\_\_\_\_ # of pay periods = \$ \_\_\_\_\_ annual pledge

**NON-REIMBURSED MEDICAL** - you must fill in all 3 blanks in the line below

\$ \_\_\_\_\_ per pay period X \_\_\_\_\_ # of pay periods = \$ \_\_\_\_\_ annual pledge

**DEPENDENT DAYCARE** - you must fill in all 3 blanks in the line below

\$ \_\_\_\_\_ per pay period X \_\_\_\_\_ # of pay periods = \$ \_\_\_\_\_ annual pledge

I do not wish to participate in my Employer sponsored Flexible Benefit Plan. I understand I will not be eligible to participate as of any date prior to the next Plan Year effective date, unless a Change in Election Event occurs and all conditions to changing my election are satisfied, as provided in the Plan.

**ELECTION FORM and SALARY REDUCTION AGREEMENT  
FLEXIBLE BENEFITS PLAN, CONTINUED**

You may be provided with a Benefits Card, as allowed by the IRS under applicable Sections of the Tax Codes. You may use the Card **only** at qualified locations for **eligible products and services** under your specific Plan.

**Using your Benefits Card:**

1. Read the front and back of the Cardholder Agreement that comes with your Card carefully. Record your Card number on the Agreement and retain it for your records.
2. Sign the back of your Card before using it.
3. Retain all receipts and documentation from your Benefits card transactions to prove expenses are eligible under your Plan Guidelines and applicable regulations established by the IRS. If requested by the administrator, Innovative Employee Benefits, Inc. you are obligated to submit your Benefits card transaction receipts and/or any other related claim information and documentation as deemed necessary to substantiate the eligibility status for the service/purchase. Failure to submit such documentation may result in: 1) the expense being deemed ineligible in which case you would be obligated to repay the amount to the Plan and/or 2) immediate suspension or revocation of the Card; and/or 3) taxable, payroll deductions by your Employer of the ineligible expenses.
4. Visit [www.better-benefits.com](http://www.better-benefits.com) to obtain up-to-date account balance information; to view or print your statement of activity, and/or to report your Card lost or stolen.

**I would like to have an extra Benefits Card for my spouse and/or my dependents I have listed below:**

| Name | Social Security Number | Name | Social Security Number |
|------|------------------------|------|------------------------|
|      |                        |      |                        |
|      |                        |      |                        |
|      |                        |      |                        |

1. I understand that I cannot change or revoke this Agreement as of any date prior to the next Plan year effective date, unless a Change in Election Event occurs and all conditions to changing my election are satisfied, as provided in the Plan. I understand my benefit elections may not be reduced below the amount that has been taken pre-tax as of the date of the eligible Election Event.
2. Any funds remaining in my reimbursement accounts at the end of the plan year will be forfeited by IRS regulations to my Employer's Plan.
3. If my employment terminates for any reason, I understand expenses must be incurred and submitted within the time frames set out in the Plan.
4. I understand the procedures for requesting reimbursement and any reimbursement must be for an eligible expense incurred during the applicable Plan Year.
5. Before the first day of each Plan Year, I will be offered the opportunity to modify my elections for the following Plan Year.
6. My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan if my Employer in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue code or the regulations thereunder.

\_\_\_\_\_  
**Employee's Signature\***

\_\_\_\_\_  
**Date\***

*\*Your signature and the date (which must be prior to the effective date) are required to process your enrollment.*

**To be completed by Employer:**

Indicate applicable Pay Cycle:

( ) W = Weekly                      ( ) B = Bi-Weekly                      ( ) S = Semi-Monthly                      ( ) M = Monthly