Flexible Spending Account Election Form

SECTION 1: Employee Contact information

EMPLOYEE NAME: LAST | FIRST/MIDDLE INITIAL | LAST FOUR DIGITS OF SOCIAL SECURITY NO.

COMPANY NAME | DAYTIME PHONE NUMBER | EMAIL ADDRESS ❍ check if new

HOME ADDRESS: STREET ❍ check if new | CITY | STATE | ZIP

SECTION 2: Election Information

Health Care Reimbursement Plan

❍ I elect to participate.

$_____ is my PRE-TAX annual election. *Cannot exceed $2,650 annually.*

❍ I elect NOT to participate.

Dependent Care Reimbursement Plan

❍ I elect to participate.

$_____ is my PRE-TAX annual election. *Cannot exceed $5,000 annually or $2,500 for an employee who is married and filing a separate tax return).*

❍ I elect NOT to participate.

Benefit MasterCard

❍ I would like to receive one additional Benefit MasterCard for use by an eligible dependent.

DEPENDENT NAME: LAST | FIRST | MIDDLE INITIAL

LAST FOUR DIGITS OF SOCIAL SECURITY NO. | DATE OF BIRTH

By signing this form, I understand that I am authorizing funds to be taken from my paycheck on a PRE-TAX basis and transferred into my Flexible Spending Account. The amount that I am requesting to be deducted will reduce my annual taxable wages. I understand that my election into the Health Care and Dependent Care Plan(s) cannot be changed during the plan year unless I experience a qualifying change in status. My election into the Parking Plan and/or Transit Plan may be changed on a monthly basis.

X

EMPLOYEE SIGNATURE VERIFICATION **DATE**

SECTION 3: Direct Deposit Information (Please Be Advised A Copy Of Cancelled Check Is Required With This Form In Order To Reimburse By Direct Deposit)

DEPOSITORY NAME | BRANCH

CITY | STATE | ZIP

ROUTING NUMBER | ACCOUNT NUMBER | ACCOUNT TYPE

I hereby authorize PlanSource, hereinafter called COMPANY, to initiate credit entries to my account indicated above at the depository financial institution named above, hereinafter called DEPOSITORY, and to credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

SECTION 4: Authorization To Use Or Disclose Identifiable Health Information

I, _____, authorize the use and disclosure of all identifiable health information pertaining to reimbursements I file under the flexible benefits plan by or to my spouse or personal representative, _____. The disclosure of identifiable health information may be made at the request of this individual. This authorization is valid during the plan year for which I am electing to participate in the Flexible Benefits Plan. I understand that I do not have to sign this authorization to be eligible to participate in the Flexible Benefits Plan and I also understand that at any time I have the ability to revoke this authorization.

X

EMPLOYEE SIGNATURE VERIFICATION **DATE**

X

SIGNATURE OF SPOUSE OR PERSONAL REPRESENTATIVE **DATE**

FOR EMPLOYER USE ONLY:

Employee Division _____ End Date _____

Effective Date _____ Date of first paycheck under the plan _____

Plan Year Start Date _____