BENEFIT ENROLLMENT FSA

Employee Name:_____ Social Security No: _____

Address:_____ City, State, Zip: _____

Employer:_____ Current Cafeteria Plan Year Begin Date: **10/1/2016**

Hire Date:_____ Effective Date:

OFFICE USE
HCE: ____
KEY: ____
5%+: ____
>25K: ____

Listed below are the benefit(s) that you have elected in the current plan year, along with the amount(s) currently being deducted from your salary. **To elect amounts for the next plan year**, please enter your initials to accept the current deductions, or enter an appropriate new deduction amount and your initials to accept the new amount. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit Description	Current Employee Deduction Amount	Current Employee Deduction Frequency	Coverage Termination Date if Applicable	Initial to Accept Current Deduction Amount	New Employee Deduction Amount	Initial to Accept New Deduction Amount

I, _____, hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown above. Such reductions, considered as benefit elective contributions under the plan, will start with my first paycheck dated after the effective date of the **next plan year** and will continue for each pay period until this agreement is amended or terminated**.** I further authorize future adjustments in the amount of the benefit election in the event of changes in the cost of coverage in any program selected above. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed.

Please contact the Plan Service Provider or your Payroll Department as soon as possible if you do not agree.

I have read the Summary Plan Description with the Plan information Summary given to me.
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 received with the Summary Plan Description.

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

Signature_____ Date_____

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

Signature_____ Date_____

DISCLOSURE STATEMENTS

I cannot change or revoke this Benefit Election Agreement before the beginning of the next Plan Year unless a Change In Family Status occurs. For this purpose, a Change In Family Status includes marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment, taking an unpaid leave of absence, and such other events recognized by the Internal Revenue Service. Further, I understand that any requested change must be on account of and consistent with the Change In Family Status.

My execution of this Benefit Election Agreement does not begin coverage under any benefit or insurance policy. The terms and conditions of the underlying benefit plan or insurance policy will determine my entitlement to benefits thereunder.

Prior to the beginning of each Plan Year, I may be offered the opportunity to change my benefit election(s) for the following Plan Year. If I fail to submit a Benefit Election Agreement at that time, I will continue any coverages (other than Medical and Dependent Care Expense Reimbursement) for the new Plan Year, and I will continue to have amounts withheld from my salary for such coverage. I understand that I must submit a new benefit election form for coverage under the Medical and Dependent Care Expense Reimbursement plans prior to the beginning of each subsequent Plan Year.

I understand that any amount remaining in my Medical or Dependent Care Expense Reimbursement Account after the end of the Plan Year will be forfeited. I also agree, upon demand, to indemnify the employer for any liability it may incur for failure to withhold federal or state income taxes or FICA taxes from any non-qualifying reimbursement I receive in connection with the Medical and/or Dependent Care Expense Reimbursement Plans.

Health and medical insurance benefits may be subject to federal and state taxes when the premiums for such coverage are paid on a pre-tax basis. If the amount of claim payments exceeds the amount of medical expenses I have incurred with regard to any particular event, the excess amount will be taxable to me. In addition, I understand that paying for disability coverage with pre-tax premiums causes disability benefits to be taxable. I understand that I am solely responsible for the payment of taxes with regard to any insured benefit, and agree to consult my own tax advisor with regard to such matters. I further understand that paying for such coverage on an after-tax basis may preserve the excludability of accident or health insurance benefits.

FLEXIBLE SPENDING ACCOUNTS

Enrollment/Decline Form

Name: _____

Social Security Number: _____

If you elect to participate in the Medical Care Expense Reimbursement Flexible Spending Account Plan, any insurance premiums you pay for the year will automatically be paid under the Plan with pretax dollars and/or other medical or dependent care (i.e. child care or day care).

Please check the appropriate section below if you wish this coverage. If you choose not to participate in the Plan please check the appropriate line.

_____ I elect to participate in the Flexible Plan and have my health insurance premiums deducted from pretax dollars.

_____ I elect **NOT** to participate.