# Section 125 Cafeteria Plans
## Election Form and Compensation Reduction Agreement

| OFFICE USE ONLY<br>First Deduction: | Termed Employee<br>Last Deduction: |
|---|---|
| ______ | ______ |

Date: ______
Fax- # of Pages: ______

Employee Name: ______ Employer: ______ Plan Year: ______ Eligibility Date: ______

Address: ______ City: ______ State: ______ Zip Code: ______ Phone Number: ______

SSN: ______ Email Address: ______ Date of Hire: ______ ☐ Open Enrollment ☐ New Hire

## Step 1: Employee and Dependent Information (Spouse, Child, etc.)

| Name | SSN | Date of Birth | Relationship | Gender | Name | SSN | Date of Birth | Relationship | Gender |
|---|---|---|---|---|---|---|---|---|---|
| | | | | ☐ M ☐ F | | | | | ☐ M ☐ F |
| | | | | ☐ M ☐ F | | | | | ☐ M ☐ F |
| | | | | ☐ M ☐ F | | | | | ☐ M ☐ F |

If I participate in my employer's insurance plan(s), my premiums will automatically be deducted pre-tax unless I notify my Human Resources Department. I understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect the increase or decrease. Prior to the first day of each plan year, I have the opportunity to change my benefit election for the following plan year. I cannot change or revoke this election at any time during the Plan year, unless I have a change in status as the Plan Administrator determines will permit a change or revocation of an election.

## Step 2: Please select the benefit plans(s) and coverage tier(s) for which you are enrolling. Please check the "Waive Coverage" box if you are waiving coverage on any of the plans.

| Name or Description of Benefit Plan | Employee Only | Employee & Spouse | Employee & Child | Employee & Children | Employee & Family | Waive Coverage | Deduction Frequency | Effective Date |
|---|---|---|---|---|---|---|---|---|
| | | | | | | ☐ | | |
| | | | | | | ☐ | | |
| | | | | | | ☐ | | |

**Flexible Spending Account (FSA)** **Full Plan Year Election $** ______ **Pay Per Period Amount $** ______ ☐ **Waive**

**Dependent Care Assistance Plan (DCAP)** **Full Plan Year Election $** ______ **Pay Per Period Amount $** ______ ☐ **Waive**

## Step 3: Reimbursement Options

If my employer has adopted the mySourceCard® MasterCard® Debit Card, I request a debit card to be issued for: ☐ Myself ☐ My Spouse Spouse's Name: ______

If my employer has elected Direct Deposit, my bank account is a: ☐ Savings ☐ Checking Bank Name ______ Account # ______ Routing # ______

## Step 4: Acknowledgement and Signature

I understand the following:

1. I authorize that my periodic paychecks for the plan year be reduced on a pro-rata pre-tax basis by the sum of premium contributions, medical Flexible Spending Account (FSA) and Dependent Care Assistance Plans (DCAP) as allocated in the benefits selected above.
2. Any expenses I incur must be within the plan year.
3. Any expense I incur must not be covered by any other source such as insurance.
4. I must provide proper documentation to receive payment.
5. I can not change or revoke my elections during the plan year unless there is a specific change of status and my employer allows such changes. Please see the Summary Plan Description (SPD) for details.
6. I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as certified in the SPD.
7. I understand that any unused dollars remaining in my account at the end of the plan year are subject to the IRS Regulation, "Use-It-Or-Lose-It" Rule. There is a typical run-out period for me to submit claims that were incurred during the plan year. In addition, the plan year may be extended through a "Grace Period" if adopted by my employer. Please refer to the SPD.
8. I understand that in the event of a lay-off or termination that my plan year will end on the date of the lay-off or termination.

Employee Signature: ______ Date: ______ Employer Signature: ______ Date: ______