



FLEXIBLE SPENDING PLAN Election Form

Company Name: _____ Year _____ Email Address _____

Employee Name: _____ Social Security #: _____ D.O.B.: _____

Employee Address: _____ City, State, Zip _____

The Company and I hereby agree that my payroll compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

1. Election and Payroll Reduction Agreement for Health Care Reimbursement

_____ I elect to participate in the **Flexible Spending Account** program for the plan year.

Amount of payroll reduction: \$ _____ per each pay period which is a total of \$ _____ for the plan year.

_____ I do not wish to participate in the Health Care Reimbursement program portion of the Flexible Spending Account (FSA).

2. Election and Payroll Reduction Agreement for Day Care Reimbursement

_____ I elect to participate in the **Dependent Care Reimbursement** program for the plan year. The maximum deposit is **\$5,000/year**.

Amount of payroll reduction: \$ _____ per each pay period which is a total of \$ _____ for the plan year.

_____ I do not wish to participate in the Dependent Care Reimbursement program portion of the Flexible Spending Account (FSA).

3. Election and Payroll Reduction Agreement for Transit/Parking Reimbursement

_____ I elect to participate in the **Transit/Parking Reimbursement** program for the plan year. The maximum deposit is **\$230/month** for Transit and **\$230/month** for Qualified Parking.

Amount of payroll reduction: \$ _____ per each pay period which is a total of \$ _____ per month for Transit.

Amount of payroll reduction: \$ _____ per each pay period which is a total of \$ _____ per month for Parking.

_____ I do not wish to participate in the Transportation Reimbursement program portion of the Flexible Spending Account..

I understand that reimbursement will be available only for "qualifying Health Care, Dependent Care and Transportation expenses". I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense, I also agree to indemnify and reimburse the Company on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand that if I do not use the Health Care and Dependent Care contributions for eligible expenses, I will lose the contributions.

Other Terms and Conditions

I understand that I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).

This agreement is subject to the terms of the Company's Health Care Reimbursement Plan, Dependent Care Assistance Plan, and/or Transit Plan as amended from time to time. It shall be governed by and construed in accordance with applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan(s).

Employee's Signature _____ Date _____

To be completed by Employer

Occupation: _____ Salary _____

Date of Hire _____ Election ___ Change ___ Effective Date _____ Date of 1st payroll deduction _____

Accepted and agreed to by the Company's Authorized Representative

By: _____ Date _____