

Paychex Use Only
Client BIS ID _____



**Election Form/Compensation Reduction Agreement
Including Employer Contribution
Flexible Spending Account**

SECTION 1 - EMPLOYEE INFORMATION (print)

Company Name _____	Office/Client Number _____
Employee Name _____	Employee Telephone Number (____) _____ - _____
Address _____ City _____ State _____ Zip Code _____	Social Security Number _____
E-mail Address _____	

SECTION 2 - ENROLLMENT OPTIONS (select one)

<input type="checkbox"/> New Enrollment or Annual Enrollment Changes Date of Hire _____ / _____ / _____ Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met. Annual enrollment changes will be effective on the first payroll following January 1. <input type="checkbox"/> Debit Card Dependent's name (if applicable) _____ Notes: Participants may only request a debit card if their employer has selected the service. If the debit card option is selected and the Plan does not offer the debit card service, no card will be requested. Refer to your Summary Plan Description for plan features. Participants may choose only one dependent.	<input type="checkbox"/> Change In Status Date of Event _____ / _____ / _____ Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to the Employer within 30 days of the event. <input type="checkbox"/> Dependent care cost provider changes <input type="checkbox"/> Dependent satisfies or ceases to satisfy dependent eligibility requirements <input type="checkbox"/> Birth/Death of spouse or dependent, adoption or placement for adoption <input type="checkbox"/> Spouse's employment commenced/terminated <input type="checkbox"/> Status change from full-time to part-time or vice versa by employee or spouse* <input type="checkbox"/> Eligibility or Ineligibility of Medicare/Medicaid <input type="checkbox"/> Change from salaried to hourly or vice versa* <input type="checkbox"/> Marriage/Divorce/Legal Separation <input type="checkbox"/> Unpaid leave of absence by employee or spouse <input type="checkbox"/> Return from unpaid leave of absence by employee or spouse <input type="checkbox"/> Termination of employment (you will be de-enrolled) <small>* These changes are allowable only if eligibility is affected.</small>
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SECTION 3 - ENROLLMENT ELECTION

<input type="checkbox"/> Annual Dependent Care Election \$ _____ <small>(Employee Contribution - DCA) Maximum \$5,000.00</small>	<input type="checkbox"/> Annual Dependent Care Election \$ _____ <small>(Employer Contribution - DCA)</small>
<input type="checkbox"/> Annual Medical/Dental/Vision Election \$ _____ <small>(Employee Contribution - UME)</small>	<input type="checkbox"/> Annual Medical/Dental/Vision Election \$ _____ <small>(Employer Contribution - UME)</small>

Note: To calculate your per pay period deduction, divide your annual amount by the number of pay periods remaining in the plan year.

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year ____ / ____ / _____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. As a participant I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

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| <ul style="list-style-type: none"> ❖ If I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election already in effect for the new plan year. ❖ I cannot change or revoke this agreement at any date prior to the next plan year unless I have a change in status as set forth under the Plan. Prior to my next plan year I will be offered the opportunity to change my benefit election for the following year. ❖ My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated. ❖ The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code. ❖ The amount of my compensation reduction will be credited to the appropriate reimbursement account held by the Employer for payment of eligible expenses incurred within the plan year. | <ul style="list-style-type: none"> ❖ The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change. ❖ Reimbursement will be available only for qualifying expenses as described in the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense. ❖ If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount. ❖ If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses. |
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Employee Signature _____	Date _____ / _____ / _____
Employer Signature _____	Date _____ / _____ / _____

ENROLL or REVISE ENROLLMENT at <https://benefits.paychex.com> or on the FSA Information Line by dialing 1-877-244-1771, Flexible Spending option. MAIL or FAX to Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: 585-389-7349