

Flexible Benefits Plan Election Form and Salary Reduction Agreement



Plan Year _____ to _____
Month Day Year Month Day Year

Employer: _____ SS# _____

Name: _____

Address: _____

City, State, Zip: _____

Email Address: _____ @ _____

Effective Date _____

I decline to participate in this Plan.

I understand that my declination will be valid for the Plan Year referenced above, and that I may not make changes without a qualifying event.

I elect to receive the following benefits under the Plan.

My Employer and I hereby agree that my salary will be reduced by the amounts set forth below for each pay period during the Flexible Benefits Plan Year listed above.

Benefit Option	Annual Election Amount	# of Pay Periods	Reduction Amount Per Pay Period
Health Care FSA	\$		\$
Dependent Care Assistance Plan (DCAP)	\$		\$
Other (please specify): _____	\$		\$
Totals	\$		\$

I understand that:

- I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the 12 month period known as the Plan Year, unless the change is due to a change in family status (i.e. marriage, divorce, death of a spouse or child, termination or commencement of employment of spouse), or other such events as the Plan Administrator determines will permit a change or revocation of an election under the Internal Revenue Code, as amended.
- If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease.
- Prior to the first day of each Plan Year, I will be offered the opportunity to change my elections for the following Plan Year. A new election must be made for each plan year. This election revokes any prior election I have made.
- The Plan Administrator may reduce or cancel my salary reduction or otherwise modify this Agreement should it believe advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my salary under this agreement shall be in addition to any other reduction agreements or benefit plans.
- This Salary Reduction Agreement reduces my compensation for Social Security tax purposes. Social Security benefits could be decreased due to the decreased amount of compensation that is considered for Social Security Purposes.
- **Any unused balance** of the reimbursed accounts will be forfeited by me back to my Employer at the end of the Plan Year.

This agreement is subject to the terms of the Employer's Flexible Benefit Plan as may be amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under the applicable laws, and revokes any prior election and salary reduction agreement (if any) relating to such a plan.

Employee Signature: _____ Date: _____

Plan Administrator Signature: _____ Date: _____

Please return form to:
 HealthSmart Benefit Solutions
 P.O. Box 71489, Newnan, GA 30271-1489
 Fax: 877.587.4434 Email: nngg_cs@healthsmart.com
 Phone: 800.503.9098