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Benefit & Risk Management Services

ELECTION FORM/COMPENSATION REDUCTION AGREEMENT

FLEXIBLE SPENDING ACCOUNT

EMPLOYEE INFORMATION – All participants must re-enroll for each plan year

COMPANY/EMPLOYER NAME *Please type or print all information*	**CLIENT # (BRMS USE ONLY)**
EMPLOYEE NAME	**DATE OF HIRE**
SOCIAL SECURITY NUMBER	**EMPLOYEE PHONE NUMBER** *Include Area Code*
STREET ADDRESS **CITY** **STATE** **ZIP**	

NUMBER OF PAYCHECKS (FROM WHICH FSA DEDUCTIONS ARE TAKEN) RECEIVED ANNUALLY:_____

	$/Pay Period		# of Pay Periods		Total Election
☐ Medical Expense Reimbursement (up to $2,500)	_____	X	_____	=	_____
☐ Dependent Care Reimbursement (up to $5,000)	_____	X	_____	=	_____

In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning ____/____/____and ending ____/____/____. 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 Adoption Agreement and Summary Plan Description.

- 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 in the Adoption Agreement and Summary Plan Description. Prior to my next plan year I will be offered the opportunity to change my benefit election for the following year.
- 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 on the attached form. 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.
- Reimbursements are based on the date services are provided and NOT on the date I pay for a service. Further, I fully understand that reimbursements are based on the amount I owe for qualified expenses and NOT on the amount I pay.
- The elections I have made are annual elections and my employer is allowing me to make my contributions each pay period for the sole purpose of making participation in the Plan as convenient as possible.
- I will forfeit contributions left unclaimed in my FSA's more than the run out period stated in my Summary Plan Description (active Participants). If I terminate employment during the plan year, I will forfeit contributions left unclaimed as stated in my Summary Plan Description. I understand that I will be offered COBRA as Federal Law mandates (Health FSA only), as applicable.
- Tax-free reimbursements from my FSA's may only be made for qualified expenses incurred (date of service) during the plan year and may not be carried over into future plan years.
- By participating in the FSA, I could potentially slightly reduce my social security benefits.
- My employer may modify or revoke my elections in any way it deems necessary in order to maintain the cafeteria plan in full compliance with all applicable provisions of the Internal Revenue Code (IRC).
- This agreement is subject to all the terms and conditions of our cafeteria plan as amended from time to time and revokes any prior election and redirection agreement I may have completed.
- If applicable, electing to reduce my wages in order to pay for disability insurance will result in my paying all income taxes (and wage taxes during the first six month of benefit payments) on the benefit payments I receive.

Release for Selection of Dependent Care Provider (Dependent Care FSA only): I hereby certify that neither my employer nor Benefit and Risk Management Services and their directors, officers, employees, agents, successors and assigns are responsible for, and are hereby released from and against any liability, obligation, claim, demand or expense of whatsoever nature in connection with, or arising out of, (1) the original selection and continued use of such provider(s) in caring for dependent(s), and (2) all acts or omissions of such provider(s) in caring for my dependent(s), or in otherwise furnishing services to me or my dependent(s). I have reviewed my expenses with my tax advisor and have determined that my pre-tax elections are prudent and reasonable. I have compared the benefits provided by any applicable tax credits and have determined that my election is in my best interest.

I authorize the above elections and subsequent adjustments to my base annual salary. I am aware that I have a grace period to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited.

Employee Signature **Date**

To be completed by Employer(Authorized Signature) ☐ **Key** ☐ **Highly Compensated** ☐ **Owner**	**Date Accepted** (Effective Date)	**Date of 1st Deduction**

REVISED 2012/6