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# Flexible Benefit Plan 2008 Plan Participation Form

Group Plan # \_\_\_\_\_  
Member Effective Date \_\_\_\_\_

Company Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee ID # \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Hire Date \_\_\_\_\_

Birth Date: \_\_\_\_\_

## FLEXIBLE SPENDING ACCOUNTS

### Request to Participate

### Benefit Elections

A.) Medical / Dental / Vision Care

\$ \_\_\_\_\_ /Year

The cost paid by you and your dependents for annual deductibles, coinsurance, eye care, dental care, routine care, etc., which is not reimbursed by insurance.

Automatic Rollover (if Plan allows- contact Employer)

B.) Dependent Care

\$ \_\_\_\_\_ /Year

Employment related care for qualifying dependents (children under age 13, or dependent disabled adults).

**ACKNOWLEDGMENT:** My employer's benefits have been explained to me and I understand that:

- the above amounts are being selected for an entire Plan year,
- will be deducted from each paycheck on an equal basis, and
- may be changed only if certain changes occur in my family and/or employment status. (This change must be made within 31 days of the family status event and must be consistent with the event.)

I further understand that the total amount deducted for the reimbursement accounts must be used during the current Plan year or forfeited under the terms of the Internal Revenue Code (unless the Plan has been amended to allow for an extended grace period). In the event of termination of employment, expenses must be submitted within the time limit set by the Plan or reimbursement will be forfeited. If I have selected a salary reduction for childcare, I certify that the amount of childcare salary reduction does not exceed the lowest of:

- my spouse's wages,
- \$5,000, or
- \$2,500 if I am married and file a separate tax form.

(If your spouse is a student or is incapacitated, contact your Employer for the childcare limit that applies to you.)

### Request to Waive

The Flexible Benefit Plan has been explained and I elect to waive participation in Flexible Spending Account. I understand that my next opportunity to enter the Plan will be at the start of the next plan year; however, if not changed, this waiver will continue in effect indefinitely.

Signature \_\_\_\_\_ Date \_\_\_\_\_