Flexible Spending Account Participation Form

Employer: _____

Plan Year: ____ /___ /_____ to ____ /___ /_____

This Participation Form is being used to: *(Check one)*

☐ Initially enroll or annually re-enroll in the Flexible Spending Account Plan ***(complete A, B, and C)***

Plan Effective Date: ___ /___ /____

☐ Waive participation in the Flexible Spending Account Plan ***(complete sections A and C).*** Failure to submit an enrollment form by the stated deadline will constitute a waiver of participation in the Flexible Spending Account.

A. Participant Data

Employee Name:_____**DOB:**_____
Last First M.I. mm/dd/yyyy

SSN:_____ **Employee ID:** _____

Address:_____
Street

_____ _____ _____
City State Zip

E-mail Address:_____ **Phone Number:** _____

Name, Zip code, SSN, and DOB are required for Web Access

B. Initial Enrollment Box

I elect to reduce my compensation for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement) and redirect such dollars into the Flexible Spending Account Plan as set forth below.

☐ **Medical Spending Account**

☐ **Dependent Care Spending Account**

☐ **Qualified Transportation**

Annual Compensation Reduction Election	Number of Pay Periods this Plan Year	Compensation Reduction Per Pay Period
	26	
	26	
	26	

C. Signature and Authorization

I hereby certify I have read and understand the Terms and Conditions of this Plan which appear on the reverse side of this form and in the Summary Plan Description and agree to abide by said Terms and Conditions. If waiving participation, I hereby certify I fully understand the benefits available to me under this Flexible Spending Account Plan.

_____ _____
Employee's Signature **Date**

Election of Medical Reimbursements and Compensation Reduction Agreement

I understand that:

Reimbursements will be available only for "qualifying medical care expenses" as described below. I agree to notify my Employer 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 my Employer 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 nonqualifying expense, up to the amount of additional tax actually owed by me.

The agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from my Employer which, before reduction hereunder, is at least equal to the amount of that reduction.

Qualifying Medical Care Expenses

Under the Plan, I will be reimbursed only for those types of medical expenses normally deductible on my federal income tax return (without regard to the Percentage of adjusted gross income limitation).

Election of Dependent Care Assistance and Compensation Reduction Agreement

I understand that:

Reimbursement will be available only for "qualifying dependent care expenses" as described below. I agree to notify my Employer 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 my Employer 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 nonqualifying expense, up the the amount of additional tax actually owed by me.

This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from my Employer.

Qualifying Dependent Care Expenses

Under the plan I will be reimbursed only for the dependent care expense meeting all the following conditions:

1. The expenses are incurred for services rendered after the date of this election and during the plan year to which it applies.
2. Each individual for whom I incur the expenses is (A) A dependent under age 13 whom I am entitled to claim as a dependent on my federal income tax return, or (B) a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable me and, if I am married, my spouse to be gainfully employed.
4. If the expenses are incurred for services outside my household, they are incurred for the care of a dependent who is described in 2(A) above, or who regularly spends at least 8 hours a day in my household.
5. If the expenses are incurred for services provided by a dependent care center (i.e. a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of mine who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom I or my spouse is entitled to a personal tax exemption as a dependent.
8. The reimbursement (when aggregated with all other reimbursements received by me under the Plan during the same year) may not exceed the least of the following limits: a) the maximum allowed under the Plan, b) my taxable compensation (after all compensation reduction elections, c) if I am married, my spouse's actual or deemed earned income.

24HourFlex Debit Card

I agree to retain all receipts and documentation from my Flex Convenience card transactions to prove expenses are eligible under my Cafeteria Plan guidelines and, if requested, to submit copies of those receipts and any other related claim information and documentation to the contracted service provider, 24hourflex.com. I also agree that failure to submit such documentation, or use of the card to pay for ineligible expenses, may result in: 1) the expense being deemed "unqualified" in which case I would be obligated to repay the amount to the Plan, and/or 2) immediate suspension or revocation of the Card, and/or 3) taxable, payroll deductions by my Employer reimbursing the plan for the ineligible, unqualified expense.

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 as outlined in the Summary Plan Document.

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
This agreement is subject to the terms of my employer's Flexible Spending Plan, as amended from time to time, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan(s).