



**ELECTION AGREEMENT - Plan Year 01/01/\_\_\_ – 12/31/\_\_\_**

I, the undersigned employee of \_\_\_\_\_ hereby make the following election regarding the benefits available to me under the Section 125 Flexible Benefit Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular paychecks during the coming Plan Year. I understand this contribution is to be paid with pre-tax dollars. This election form cannot be revoked or changed during the plan year, unless there is a life status change. I understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years. If at the end of the plan year, my total contributions exceed my qualified expenses, the difference in amounts will be forfeited per IRS Code.

1. Medical Reimbursement:

Annual Maximum \$ \_\_\_\_\_ : \$ \_\_\_\_\_/Annual \$ \_\_\_\_\_/Per Pay Period (Annual divided by 26)

2. Dependent Care:

Annual Maximum \$ \_\_\_\_\_ : \$ \_\_\_\_\_/Annual \$ \_\_\_\_\_/Per Pay Period (Annual divided by 26)

Single/Married (filing joint tax return) Maximum Deferral - \$5,000 annual

Married (filing separately) Maximum deferral - \$2,500 annual

---

Employee's Last Name	First	MI	Telephone #	
----------------------	-------	----	-------------	--

---

Employee's Address	Street	City	State	Zip
--------------------	--------	------	-------	-----

---

Email Address	Date of Birth	Date of Hire
---------------	---------------	--------------

Select One:

I elect to have my reimbursements deposited into my bank account (authorization for automatic reimbursement form attached).

I elect to have my reimbursements mailed to the address provided above.

	Dependent Information	Sex	Date of Birth
Spouse			
Child			
Child			
Child			

**Signature** \_\_\_\_\_ **Social Security** \_\_\_\_\_ **Date** \_\_\_\_\_