# PARTICIPATION FORM FOR THE FLEXIBLE BENEFITS CAFETERIA PLAN

**Please return this form to your Employer**

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|---|---|---|
| Employer Name: | | |
| Employee Name: | | |
| Social Security #: | Date of Birth: | |
| Address: | | |
| City: | State: | Zip: |
| Email: | Phone #: | |

**OPTION I - Healthcare Flexible Spending Account Agreement**

☐ **YES** I elect to contribute $ _____(before taxes) for the PLAN YEAR which is $ _____ **per pay** period to fund my account that pays qualified out-of-pocket health care expenses not covered by my health and other insurance plans.

☐ **NO** I decline this option for this plan and understand that I will lose all tax savings that I could receive as a participant.

**OPTION I.a - Limited (Vision/Dental) Flexible Spending Account Agreement**

☐ **YES** I elect to contribute $ _____(before taxes) for the PLAN YEAR which is $ _____ **per pay** period to fund my account that pays qualified out-of-pocket health care expenses not covered by my health and other insurance plans.

☐ **NO** I decline this option for this plan and understand that I will lose all tax savings that I could receive as a participant.

**OPTION II - Dependent Care Benefit Account**

☐ **YES** I elect to contribute $ _____(before taxes) for the PLAN YEAR which is $ _____ **per pay** period to fund my account that pays qualified dependent care expenses. Maximum amount per calendar year is the lesser of: (1) $5,000 for married filing joint or $2,500 for filing separate, (2) your spouse's total annual compensation or (3) half of your total annual compensation. If you are single, the maximum is $5,000.

☐ **NO** I decline this option for this plan and understand that I will lose all tax savings that I could receive as a participant.

***My Employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge I have read and understand the Important Information on the back of this booklet***

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| **Employee Signature:** | **Date:** |