

Serviced by:

**CODE SECTION 125 CAFETERIA PLAN
Election Form and Compensation Reduction Agreement**



(Please read and complete entire form and return to Human Resources)

For Human Resources Use Only
Received Date: _____ Effective Date: _____

Section I – Employee Information (please print or type)

Employer's Name:		Group Number:	
Employee's	Name:	Date of Birth:	Social Security #:
	Street Address:		City:
	State:	Zip Code:	Work E-Mail Address:
	Date of Hire:	Number of Pay Periods: <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Other (specify) _____	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	

Acknowledgements, Agreements, and Authorizations

The Employee acknowledges, agrees, and authorizes the following:

My Employer operates a cafeteria plan and I am familiar with the terms of the plan. At the beginning of each plan year, I may volunteer to participate in the plan by electing pretax benefits or I can elect to waive any and all pretax benefits. The Internal Revenue Code does not permit owners, partners, and 2 percent or more shareholders in a Subchapter S corporation to participate in the plan.

If I elect to participate in the plan, my compensation will be reduced on a pretax basis to pay my share of the premiums for the plan benefit(s) that I elect for the plan year. This will also reduce my compensation for Social Security tax purposes. **I may not change my election before the beginning of the next plan year unless I experience a change in status that is allowed and accepted by the plan (as indicated in the plan document) and permitted under regulations issued by the Department of the Treasury.**

■■■■■■■■■■ Premium Only Account Information ■■■■■■■■■■

If I elect to participate in the **premium only account** (POA) (if available under the plan), I will be paying for my share of the premiums for the medical benefit program (amount disclosed by the Employer) on a pretax basis. My election to participate in the POA does not enroll me in or guarantee me coverage under the medical benefit program. Medical benefit program coverage is provided under separate plans and/or policies, which contain their own distinct requirements.

■■■■■■■■■■ Health Care Flexible Spending Account Information ■■■■■■■■■■

If I elect to participate in the **health care flexible spending account** (HCFSA) (if available under the plan), a pretax HCFSA will be established in my name, but no money will actually be allocated to the account. The account will be of a memorandum nature, maintained for accounting purposes. No interest will be credited to or paid on amounts credited to the account. The account will be used to reimburse me for qualifying medical care expenses, as described in the plan document, up to an annual limit (disclosed by the Employer).

I cannot request reimbursements for qualifying medical care expenses unless they are incurred by me and/or any of the following "dependents":

- My legal spouse
- A qualifying child who is a U.S. citizen, national, or a resident of the U.S., Mexico, or Canada, and –
 - Is not someone else's qualifying child,
 - Has a specified family-type relationship to me,
 - Lives in my household for more than half of the taxable year,
 - Is 18 years or younger (23 years, if a full-time student) at the end of the taxable year, and
 - Has not provided more than one-half of his or her own support during the taxable year.

(Over)

- A qualifying individual who is a U.S. citizen, national, or a resident of the U.S., Mexico, or Canada, and –
 - Has a specified family-type relationship to me, is not someone else’s qualifying child, and receives more than one-half of his or her support from me during the taxable year, or
 - If no specified family-type relationship to me exists, is a member of and lives in my household (without violating local law) for the entire taxable year and receives more than half of his or her support from me during the taxable year.

There is no age requirement for a qualifying child if he or she is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a HCFSA.

On Section 2 of this form, I will identify the individuals for whom I may request HCFSA reimbursements. If I am unsure about whether an individual is my “dependent” for HCFSA purposes, I will consult my tax advisor for assistance.

■■■■■■■■■■ Debit Card Information ■■■■■■■■■■

If elected by my Employer, a debit card will be issued to me. With the card, I may pay certain claims at the point of service using funds from my HCFSA balance for the current plan year. If applicable, I agree to all of the conditions of the debit card, including but not limited to the following:

- All claims reimbursed through the debit card are subject to Internal Revenue Service substantiation requirements. I will retain documentation of the expenses reimbursed through the card, because I may be required to substantiate transactions by providing copies of the documentation. I will provide documentation as required and requested. If I do not respond to the documentation request(s), the card may be inactivated.
- I will have sole liability and responsibility for lost or stolen cards. Lost or stolen cards must be reported to Human Resources or SBS+ during regular business hours, however, neither the Employer nor SBS will be liable for any use or misuse of lost or stolen cards.
- The card will be used only for qualifying medical care expenses (as described in the plan document). Otherwise, I will have to reimburse the plan so that amounts used for unqualified expenses can be restored to my account. If I do not reimburse the plan, my card will be inactivated.
- Any expenses that I or my dependents pay for with the card will not have been reimbursed elsewhere.
- Neither I nor my dependents will seek to have any expenses that are paid for with the card reimbursed elsewhere.
- I will be solely liable for any consequences/charges resulting from misuse of the card, including but not limited to any federal tax sanctions or assessments.

■■■■■■■■■■ Dependent Care Flexible Spending Account Information ■■■■■■■■■■

If I elect to participate in the **dependent care flexible spending account** (DCFSA) (if available under the Plan), a pretax DCFSA will be established in my name, but no money will actually be allocated to the account. The account will be of a memorandum nature, maintained for accounting purposes. No interest will be credited to or paid on amounts credited to the account. The account will be used to reimburse me for qualifying dependent care expenses as described in the plan document.

The Plan Year contribution limit for a DCFSA is set by the Internal Revenue Service. The current contribution limit for a single person or married couple is \$5,000 (\$2,500 if married and filing a separate return). Also, the contribution cannot be more than my earned income or the earned income of my spouse.

I cannot request reimbursements for qualifying dependent care expenses unless they are incurred by me and/or any of the following “dependents”:

- A qualifying child, if he or she is a U.S. citizen, national, or resident of the U.S., Mexico, or Canada, and –
 - Has a specified family-type relationship to me,
 - Lives in my household for more than one-half of the taxable year,
 - Is 12 years old or younger, and
 - Has not provided more than one-half of his or her own support during the taxable year.
- My legal spouse, if he or she –
 - Is physically and/or mentally incapable of self-care,
 - Lives in my household for more than one-half of the taxable year, and
 - If care is provided outside my household, spends at least 8 hours per day in my home.

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- My qualifying relative, if he or she is a U.S. citizen, national, or resident of the U.S., Mexico, or Canada, and –
 - Is physically and/or mentally incapable of self-care,
 - Is not someone else’s qualifying child,
 - Lives in my household for more than one-half of the taxable year,
 - If care is provided outside my household, spends a least 8 hours per day in my home, and
 - Receives more than one-half of his or her support from me during the taxable year.

For divorced or legally separated parents, the only parent who may receive reimbursements under the DCFSA is the custodial parent (the parent with whom the child lives for the greater portion of the taxable year), even if the non-custodial parent provides more financial support than the custodial parent.

On Section 2 of this form, I will identify the individuals for whom I may request DCFSA reimbursements. If I am unsure about whether an individual is my “dependent” for DCFSA purposes, I will consult my tax advisor for assistance.

No Dependent Care Tax Credit is permitted for amounts reimbursed under the DCFSA. I must take into account the relative tax benefits that result from choosing DCFSA reimbursement versus claiming the Dependent Care Tax Credit. If I am unable to determine the best approach for me, I will consult with my tax advisor for assistance.

■■■■■■■■■■ Miscellaneous ■■■■■■■■■■

The compensation reduction I elect for any one account cannot be transferred to another account.

Any amounts remaining in each pretax account after the last day for incurring claims for the plan year will be forfeited, unless submitted for reimbursement by the last day of the plan’s claim filing period.

This election will automatically terminate if the Plan is terminated or if I cease to receive compensation from the Employer, except as otherwise required under the applicable provision of the Consolidated Omnibus Budget Reconciliation Act regarding continuation of health care benefits.

Neither the Employer nor SBS makes a commitment or guarantee that any amounts paid to or for my benefit under the plan will be excludable from my gross income for federal taxes or that any other favorable tax treatment will apply to or be available with respect to such amounts. It will be my obligation to determine whether each payment under this plan is excludable from my gross income for tax purposes, and to notify Human Resources if I have reason to believe that any payment is not excludable. I will indemnify and reimburse the 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 for an unqualified expense, up to the amount of additional tax actually owed by me.

If I fail to submit this form prior to the deadline given by my Employer, I will be treated as having elected *not* to participate in the plan for the plan year. My Employer may reduce or cancel the amount of my compensation reduction or otherwise modify my election if the Employer believes such to be advisable to satisfy certain provisions of the Internal Revenue Code.

Section II – Election of Participation (please print or type)

By my signature below, I authorize the Employer to make salary reduction contributions on my behalf to the following accounts for the plan year in the amounts indicated below under “my contribution.” Pretax contributions will not be used to fund a Health Reimbursement Arrangement, if offered by my Employer.

POA (If offered under the Plan) My contribution: \$ _____ Or <input type="checkbox"/> Decline Account	HCFSA (If offered under the plan) My contribution: \$ _____ Employer contribution (if any): \$ _____ Or <input type="checkbox"/> Decline Account	DCFSA (If offered under the plan) My contribution: \$ _____ Employer contribution (if any): \$ _____ Or <input type="checkbox"/> Decline Account
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	Dependent’s Name	Relationship to Employee	Social Security #	Date of Birth	Type of Dependent Coverage
Dependents for whom reimbursements will be requested:					<input type="checkbox"/> HCFSA <input type="checkbox"/> DCFSA <input type="checkbox"/> Both
					<input type="checkbox"/> HCFSA <input type="checkbox"/> DCFSA <input type="checkbox"/> Both
					<input type="checkbox"/> HCFSA <input type="checkbox"/> DCFSA <input type="checkbox"/> Both
					<input type="checkbox"/> HCFSA <input type="checkbox"/> DCFSA <input type="checkbox"/> Both
					<input type="checkbox"/> HCFSA <input type="checkbox"/> DCFSA <input type="checkbox"/> Both

Signed (by Employee): _____ Date: _____

Employer Authorization: _____ Date: _____

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