Universal Plan Administrators

1053 21st St., Lewiston ID 83501
208-746-7046

Sec. 125 Cafeteria Plan Flexible Spending Account
Benefit Election Form and Salary Reduction Agreement

OFFICE USE	
HCE:	____
KEY:	____
5%+:	___
>25K:	____

Washington Odd Fellows Home

Employer Name | Plan Year

Employee Name (Last, First, MI) | Social Security No.

Employee Street Address | City, State, Zip Code

Date of Birth | Employee Email Address | Payroll Effective Date

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the Reimbursement Accounts headings shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date of the Plan. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

Listed below are the benefits that may be available under the plan. Please indicate which benefits you wish to select by completing the total per deduction-period cost and the amount paid by the pre-tax reduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefit (All amounts paid should be per deduction period) **Salary Reduction per Pay Period**

Reimbursement Accounts

FSA Medical Expenses..... $_____

Individual Policy…… $_____

FSA Dependent Care..... $_____

FSA Limited Purpose Expenses..... $_____

Total Deductions per pay period……...$0_____

This election form will remain in effect and cannot be revoked or changed during the plan year, unless I have a change in Family Status. If allowed by Employer your plan may have up to $500 carry-over of FSA Medical expenses into the next plan year.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate.**

Signature_____ Date_____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate.**

Signature_____ Date_____

DISCLOSURE STATEMENTS

I cannot change or revoke this Benefit Election Agreement before the beginning of the next Plan Year unless a Change In Family Status occurs. For this purpose, a Change In Family Status includes marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment, taking an unpaid leave of absence, and such other events recognized by the Internal Revenue Service. Further, I understand that any requested change must be on account of and consistent with the Change In Family Status.

My execution of this Benefit Election Agreement does not begin coverage under any benefit or insurance policy. The terms and conditions of the underlying benefit plan or insurance policy will determine my entitlement to benefits thereunder.

Prior to the beginning of each Plan Year, I may be offered the opportunity to change my benefit election(s) for the following Plan Year. If I fail to submit a Benefit Election Agreement at that time, I will continue any coverages (other than Medical and Dependent Care Expense Reimbursement) for the new Plan Year, and I will continue to have amounts withheld from my salary for such coverage. I understand that I must submit a new benefit election form for coverage under the Medical and Dependent Care Expense Reimbursement plans prior to the beginning of each subsequent Plan Year.

I understand that any amount remaining in my Medical or Dependent Care Expense Reimbursement Account after the end of the Plan Year will be forfeited. I also agree, upon demand, to indemnify the employer for any liability it may incur for failure to withhold federal or state income taxes or FICA taxes from any non-qualifying reimbursement I receive in connection with the Medical and/or Dependent Care Expense Reimbursement Plans.

Health and medical insurance benefits may be subject to federal and state taxes when the premiums for such coverage are paid on a pre-tax basis. If the amount of claim payments exceeds the amount of medical expenses I have incurred with regard to any particular event, the excess amount will be taxable to me. In addition, I understand that paying for disability coverage with pre-tax premiums causes disability benefits to be taxable. I understand that I am solely responsible for the payment of taxes with regard to any insured benefit, and agree to consult my own tax advisor with regard to such matters. I further understand that paying for such coverage on an after-tax basis may preserve the excludability of accident or health insurance benefits.