Paychex Use Only

Client BIS ID ____________

PAYCHEX

Election Form/Compensation Reduction Agreement Flexible Spending Account

SECTION 1 - EMPLOYEE INFORMATION (print)

Office/Client Number ____________

Company Name ____________

Employee Telephone Number (___) ______ - ______

Employee Name ____________

Social Security Number ____________

Address ____________ City ____________ State _____ Zip Code ____________

SECTION 2 - ENROLLMENT OPTIONS (select one)

☐ **New Enrollment or Annual Enrollment Changes**
Date of Hire ________ / ________ / ________

Notes: New enrollments will be effective on the first payroll of the month following the date the eligibility requirements are met.

Annual enrollment changes will be effective on the first payroll following January 1.

CHECK IF APPLICABLE
Employer Added New Benefit: _____UME _____DCA

☐ **Change In Status**
Date of Event ________ / ________ / ________

Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to the Employer within 30 days of the event.

- ☐ Dependent care cost provider changes
- ☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements
- ☐ Birth/Death of spouse or dependent, adoption or placement for adoption
- ☐ Spouse's employment commenced/terminated
- ☐ Status change from full-time to part-time or vice versa by employee or spouse*
- ☐ Eligibility or Ineligibility of Medicare/Medicaid
- ☐ Change from salaried to hourly or vice versa*
- ☐ Marriage/Divorce/Legal Separation
- ☐ Unpaid leave of absence by employee or spouse
- ☐ Return from unpaid leave of absence by employee or spouse
- ☐ Termination of employment (you will be de-enrolled)

* These changes are allowable only if eligibility is affected.

SECTION 3 - ENROLLMENT ELECTION

☐ Annual Dependent Care Election $ ____________
Maximum $5,000.00

☐ Annual Medical/Dental/Vision Election $ ____________

Note: To calculate your per-pay-period deduction, divide your annual amount by the number of pay periods remaining in the plan year.

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year ____ / ____ / ____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. As a participant, I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

- ❖ If I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election already in effect for the new plan year.
- ❖ I cannot change or revoke this agreement at any date prior to the next plan year unless I have a change in status as set forth under the Plan. Prior to my next plan year, I will be offered the opportunity to change my benefit election for the following year.
- ❖ My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated.
- ❖ The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.
- ❖ The amount of my compensation reduction will be credited to the appropriate reimbursement account held by the Employer for payment of eligible expenses incurred within the plan year.
- ❖ The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- ❖ Reimbursement will be available only for qualifying expenses as described in the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- ❖ If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount.
- ❖ If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.

Employee Signature ____________ Date ________ / ________ / ________

ENROLL or REVISE ENROLLMENT at https://benefits.paychex.com or by calling Paychex Employee Services at 1-877-244-1771, Flexible Spending option. MAIL or FAX to Paychex, Section 125 Department, 1175 John Street, West Henrietta, NY 14586 • Fax: 585-389-7349