**Premium Only Plan**

**And**

**Flexible Spending Account Agreement**

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Beneficiary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the plan year beginning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and ending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby elect to participate in the Premium Only Plan and Flexible Spending Plan for the following qualifying expenses:

 Annual Per Pay Period

A. Health Care Account (see worksheet)

 The taxable compensation to be reduced annually A. $ $

 for qualifying health-care expenses is:

B. Dependent Care Account (see worksheet) B. $ $

 The taxable compensation to be reduced annually

 for qualifying dependent care expenses is:

C. Other Expenses (see worksheet) C. $ $

 The taxable compensation to be reduced annually

 for qualifying other expenses is:

D. Premium Only Plan (POP)

 List all subtotals: subtotals

 $

TOTAL AMOUNT OF PREMIUMS D. $ $

Note. The amount of compensation that you contribute into your flexible spending account(s) will be subtracted from your wages in equal amounts each pay period and deposited into The Plan.

By signing my name below, I agree or understand that:

* This election is irrevocable during the plan year except as indicated below. I also acknowledge that this election will be automatically renewed from year to year unless I revoke it before the start of the plan year in question.
* The offering organization or any of its subsidiaries may change or suspend the reduction of compensation if the Internal Revenue Service, through its legislation or restrictive regulation, limits or prohibits salary reduction as currently permitted under Section 125 of the Internal Revenue Code.
* My employer is released from all present and future rights or claims to any sums reduced from my salary and used for reimbursement of eligible expenses in accordance with the provisions of the *Flexible Benefits Plan.*
* Reduced amounts of taxable compensation not used to pay for eligible benefits during the plan year will be forfeited.
* Compensation contributed into one *FLEX* account cannot be transferred and used for expenses in any other account.
* I may change my elections only in the event of a change in my family status, as defined in The Plan, , e.g., death, disability, divorce, marriage, etc.

Further, I accept responsibility for the proper treatment of benefits paid under this plan with respect to all individual income tax reporting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

NOTE. If above elections are based on a change in your family status, fill out the following form and furnish appropriate documents to substantiate the change in the status you are claiming.

**Change in Family Status Form**

Complete this portion of the *FLEX* agreement only if you have previously enrolled in the *FLEX* plan and now wish to show a valid reason for changing or cancelling the terms of your enrollment.

□ Marriage/divorcee/legal separation (attach license, court decree, or other supporting documentation).

□ Birth, adoption, or death of a dependent.

□ Termination of your employment (or spouse’s).

□ Obtain employment (you or spouse).

□ Loss of dependent status.

□ Change in your (or spouses) employment status (i.e., from part-time to full-time, ineligible to eligible, increase or reduction in salary, etc.)

□ Other (give details and provide supportive documentation).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The amounts you indicate on this form should reflect the change(s) in contributions you desire as a result of your change of family status. The changes you elect must be consistent with the change in status checked above. Changes include, but are not limited to:

* Increasing or decreasing the amounts in medical, dependent care, or both.
* Changing coverage from *single* to *family* or from *family* to *single*.
* Cancelling your participation in the *FLEX* plan.

Attach to this signed form documents or certificates that evidence the indicated change(s) in family status. A benefits committee will review your request for change of status and either grant or deny the change. If you dispute a denial of your request, you have 60 days in which to respond. If the committee denies the request again, you may pursue other rights accorded you under the Employee Retirement Income Security Act of 1974 (ERISA).

I hereby elect these changes because of a qualified change in my family or employment status.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By Date

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

**FLEXIBLE SPENDING ACCOUNT**

**Health Care Expenses Worksheet**

A Flexible Spending Account (FSA) enables you to buy health care that is not reimbursed through the regular employer-sponsored group health plan, dental plan, or through some other source. Such care is traditionally paid for as an *out-of-pocket* expense, which means *you* pay for it. Below are some of the eligible *out-of-pocket* expenses available for reimbursement under the FSA. As you complete the worksheet, estimate only those *out-of-pocket* expenses you can reasonably expect to incur (pay) during the year.

This worksheet is for your future reference. Remember any health care expenses that could have been deducted on your income tax return are eligible for payment through the FSA. Be conservative and estimate only those expenses you are comparatively certain you will incur, then enter the total of health-care expenses on the enrollment form.

**Out-of-Pocket Expenses Payable through the Flexible Spending Account Annual Cost**

MEDICAL/DENTAL

 Physical examinations $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dental/orthodontia (exams, fillings, braces) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Well baby care (exams, newborn) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Eye examinations $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chiropractic examinations $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prescription drugs (incl. contraceptives,

 blood-pressure medication, and insulin) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Over-the-counter drugs (if prescribed by a doctor) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HMO fees $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physical therapy $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Convalescent care or private-duty nursing $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Care for handicapped (physically or mentally) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Transportation associated with health care $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL EQUIPMENT (if prescribed by physician)

 Exercise bicycle $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other exercise equipment $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Oxygen tanks $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Water purification system $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Air filter system $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hearing exams and hearing aids $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone for the deaf $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hospital bed $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Whirlpools $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MISCELLANEOUS (if prescribed by physician)

 Weight watcher $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Smoking cessation program $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Out-of-Pocket Expenses Payable through the Flexible Spending Account** **Annual Cost**

MISCELLANEOUS (continued)

 Treatment of alcoholism or substance abuse $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member in health spa $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Acupuncture $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Abortion $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE

 Your health coverage deductible $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Your dental coverage deductible $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **TOTAL COST $** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, write below the estimate of your total annual cost for the Dependent/Child Care Expenses Worksheet and then add that amount to the above total cost for the sum total of your annual expenses.

 $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Examples of Other Expenses Eligible for FSA Reimbursement**

Abortions, legal

Acupuncture

Alcoholism

Ambulance hire

Artificial limbs

Artificial teeth

Birth control pills

Birth prevention surgery

Braces

Braille - books and magazines

Care for mentally handicapped

 child

Child care expenses

Chiropractors

Co-Insurance

Cost of operations and related

 treatments

Crutches

Deductible

Dental fees

Dentures

Diagnostic fees

Drug and medical supplies

(cost which exceeds 1% of adjusted gross income)

Electrolysis

Eyeglasses, including examination

 fee

Fee of practical nurse

Fees for healing services

Fees for authorized Christian

 Science practitioners

Fees of licensed osteopaths

Handicapped persons’ special

 schools

Hair transplants

Hearing devices and batteries

Home improvements motivated by

 medical consideration

Hospitalization

Insulin

Laboratory fees

Laetrile by prescription

Lead-based paint removal

Medical information plan

Membership fees in association

furnishing medical services, hospitalization, and clinical care

Nurses' fees (including nurses' board

and Social Security tax where paid by taxpayer)

Obstetrical expenses

Operations

Orthodontia

Orthopedic shoes

Over-the-counter drugs (if prescribed

 by a doctor)

Oxygen

Physician fees

Physician-recommended swimming

pool or spa equipment costs and maintenance

Physician-recommended weight loss

or smoking cessation programs

Prescribed medicine (including

 vitamins and contraceptives)

Psychiatric care

Psychologist fees

Routine physicals and other non-

 diagnostic services or treatments

"Seeing-eye" dog and its upkeep

Special communication equipment

 or the deaf

Special diets

Special education for the blind

Special home expenses for the

 mentally handicapped

Special plumbing for the

 handicapped

Sterilization fees

Surgical fees

Therapeutic care for drug and

 alcohol addiction

Therapy treatments

Transportation expenses primarily

for rendition of medical service, i.e., railroad fare to hospital or to convalescent facility, car fare in obstetrical cases

Tuition at special school for handicapped

Tuition fee (part), if college or

private school furnished breakdown of medical charges

Vitamins by prescription

Wheelchair

Wigs

X-ray