Election Form/Compensation Reduction Agreement

Company Name:	Ivinson Memorial Hospital
Employee Name:	
Social Security Number:	
Date of Birth:	
Street Address:	
City, State, Zip:	
Telephone Number:	
Employment Date:	
Eligibility Date:	

Health Flexible Spending Account (Medical Expenses)

☐ **Yes, I elect to participate**. I request $_____ annually, which equals $_____ per pay period, be directed from my gross pay pre-tax to my Health Spending Account. I understand this is in addition to any amounts I request below for Dependent Care Expenses. I further understand that the Health Spending Account and the Dependent Care Spending Account are separate and the funds directed to the accounts may not be commingled. I also understand I may not claim expenses reimbursed through my Health Spending Account on my tax return or through another spending account.

Dependent Care Flexible Spending Account

☐ **Yes, I elect to participate**. I request $_____ annually, which equals $_____ per pay period, be directed from my gross pay pre-tax to my Dependent Care Spending Account. I understand this is in addition to any amounts I request above for Health Expenses. I further understand that the Health Spending Account and the Dependent Care Spending Account are separate and the funds directed to the accounts may not be commingled. I also understand I must file Federal Form 2441 (Child Care Credit Form) with my Federal tax return.

Other Terms and Conditions

I understand that:

An election is made before a year begins and cannot be changed until the next year. No changes are allowed during the year unless there is change of status. Change in status events include a change in: legal marital status, number of dependents, employment status, a dependent satisfies or ceases to satisfy eligibility requirements and residence.

I agree to notify the Company if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Company on demand, for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax on any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

The Plan Administrator may reduce compensation reduction or otherwise modify this agreement in the event she believes it advisable in order to satisfy provisions of the Internal Revenue Code.

My Social Security benefits may be slightly reduced as a result of my election.

This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Company which, before reduction hereunder, is at least equal to the amount of that reduction.

If my employment is terminated I agree to contact the Company regarding my account.

☐ Full Name: _____ Date: _____

I understand that by checking the above box and typing my name into the name field, this document is valid as if I have signed it.

☐ Check here to decline participation in the Flexible Spending (Section 125 Cafeteria) Plan

☐ Entered in Meditech ☐ Enrolled with UCHPA ☐ Saved in e-File ☐ PremiumsAdjusted
☐ Calendar Reminder for entering in Meditech