Administered By:

Significa℠ BENEFIT SERVICES

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 Information	Name:		Date of Birth:	Social Security #:
	Mailing Address:			City:
	State:	Zip Code:	Work E-Mail Address:	
	Date of Hire:	Number of Pay Periods: □ 12 □ 24 □ 26 □ 52 □ Other (specify) _____		
	Gender: □ Male □ Female	Marital Status: ☐ Married ☐ Single ☐ Divorced		

Acknowledgements, Agreements, and Authorizations

I acknowledge, agree, and authorize 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.**

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.

HCFSA (If offered under the plan)
My contribution: $ _____ per year
Employer contribution (if any): $ _____
Or
☐ Decline Account

DCFSA (If offered under the plan)
My contribution: $ _____ per year
Employer contribution (if any): $ _____
Or
☐ Decline Account

POA (If offered under the Plan)
My contribution: $ _____
Or
☐ Decline Account

	Dependent's Name	Relationship to Employee	Social Security #	Date of Birth
Dependents for whom reimbursements will be requested:				

Signed (by Employee): _____ Date: _____

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

If I elect to participate in the **health care flexible spending account** (HCFSA), if applicable, 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).

Note, if You enroll in a Medical Plan with the High Deductible Health Plan/Health Savings Account option or if Your spouse is enrolled in another High Deductible Health Plan with a Health Savings Account, Your pre-tax pay cannot be allotted to the General Purpose Health Care Flexible Spending Arrangement. As an alternative, Your pre-tax pay can be allotted to the Limited Purpose Health Care Flexible Spending Arrangement.

Under the Limited Purpose Health Care Flexible Spending Arrangement, reimbursements are limited to Eligible Health Care Expenses for dental and vision care services and products that meet the IRS definition of medical care. In addition, the expenses cannot be paid by Your Medical Plan coverage or any other insurance.

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.

If permitted by my plan a dependent may also include a child who does not attain age 27 during my taxable year and has the following relationship to me: son/daughter or stepson/stepdaughter, eligible foster child, legally adopted child or legally placed with me for adoption. Ask Human Resources if this provision applies.

- 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, please identify the dependents for whom reimbursements will be requested. If you are unsure about whether an individual is a "dependent" we recommend you consult with your 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 applicable, 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,
  - Up to age 13 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.

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.

Reminder: No Dependent Care Tax Credit is permitted for amounts reimbursed under the DCFSA. You must take into account the relative tax benefits that result from choosing DCFSA reimbursement versus claiming the Dependent Care Tax Credit. If you are unable to determine the best approach, we recommend you consult with your tax advisor for assistance.

■■■■■■■■■■■■■ Miscellaneous ■■■■■■■■■■■■■

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

Subject to any carry over provision that the Plan may permit, 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.