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THE OPEN SOLUTION™

# FLEXIBLE SPENDING ELECTION/CHANGE FORM

FLEXIBLE
SPENDING
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| | | | |
|---|---|---|---|
| **Employee Name:** | | **Company Name:** | |
| **Address:** | | **City, State, ZIP:** | |
| **SS Number:** | | **Date Submitted:** | |
| **Home Phone:** | | **Work Phone:** | |

I hereby direct and authorize my employer to reduce my salary by the amount of the cost to me for the benefits shown below. Such reduction shall commence with my pay check dated _____. I further authorize future additional reductions in the event that the cost of coverage in any program selected is significantly changed during the Plan Year. This election is effective for plan year _____ through _____ .

## PREMIUM CONVERSION ELECTION AND REDUCTION REQUEST

| **Premium Conversion Insurance Benefits*** | **Yes** | **No** | **Amount Per Pay Period** | |
|---|---|---|---|---|
| Group Term Life | _____ | _____ | $_____ | |
| Medical | _____ | _____ | $_____ | |
| Dental | _____ | _____ | $_____ | |
| Long-Term Disability | _____ | _____ | $_____ | |
| Short-Term Disability | _____ | _____ | $_____ | |
| _____ | _____ | _____ | $_____ | TOTAL$_____ |

This election is **NOT** an application for the corresponding insurance benefit.
In most instances, you must complete an insurance application.

## FLEXIBLE COMPENSATION ELECTION AND REDUCTION REQUEST

| **Flexible Reimbursement Accounts** | **Yes** | **No** | **Amount Per Pay Period** | **No. of Pay Period*** | **Annual** |
|---|---|---|---|---|---|
| Unreimbursed Medical Account | _____ | _____ | $ _____ | X_____ | = $ _____ |
| Dependent Care Account | _____ | _____ | $ _____ | X_____ | = $ _____ |
| | | | | **TOTAL $** | _____ |

### DEPENDENT CARE LIMITATIONS

The total amount to be deposited into your Dependent Care FSA cannot exceed the lesser of $6,000.00 ($3,000 for a married person filing separately) or your spouse's earned income, (your spouse will be deemed to have earned income of $250.00 per month if he/she is a full time student for five months or disabled.) If your spouse does not work or is not disabled or a fulltime student, you cannot participate in Dependent Care FSA. A dependent is defined as your child/stepchild under age 13 and for whom you may claim an exemption or deduction, or other such dependents of any age as described in Section 152 of the IRC who are physically or mentally incapable of self care.

### FAMILY STATUS CHANGES

This election form will remain in effect and cannot be revoked or changed during the Plan Year, unless the revocation and new election are on account of and consistent with a change in family status e.g.,

- marriage, divorce or legal separation;
- birth or adoption of a child of the employee;
- the termination or commencement of employment of the employee's spouse, the switching from part-time to full-time employment status or from full-time to part-time status by the employee or the employee s spouse, and the taking of an unpaid leave of absence by the employee or the employee's spouse;
- the death of a dependent;
- significant change in the health coverage of the employee or the spouse of the employee attributable to the spouse's employment;
- termination of employment of the employee; or
- significant change in cost of coverage.

**I elect to change my salary reduction amount from $ _____ to $ _____ , due to the following family status change.**

☐ Legal Separation, divorce or marrage ☐ Birth or legal adoption of a child ☐ Death of spouse/ dependent ☐ Change in work status for you / spouse ☐ Other:_____

**I elect to suspend my salary reduction due to the following stated family status change.**

☐ Legal Separation, divorce or marrage ☐ Birth or legal adoption of a child ☐ Death of spouse/ dependent ☐ Change in work status for you / spouse ☐ Other:_____

**It is my responsibility to keep documented records** in order to verify reimbursements I might receive. I also understand that should I fail to spend the above flexible spending account funds within the benefit year, **such funds are forfeited.**

Participant's Signature _____ Date _____

I have been given the opportunity to participate in the Flexible Compensation Program, however, I do not desire to participate at this time.

Participant's Signature _____ Date _____