Section 125 Election Agreement Form **Employer: Tusculum College** **Plan Year: Apr 1, 2017 – Mar 31, 2018**

PERSONAL

Employee Name (Last, First, MI): _____ Social security number: _____

Address Line 1: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Gender: ☐ **Male** ☐ **Female** Date of birth: _____

EMPLOYMENT

Hire date: _____ Work phone: _____

Class: ☑ **W2 Employee** ☐ **1099 Contractor (Note – not permitted)**

NOTE: Sole proprietors, partners, members, and shareholders > 2% ownership of S corporations (and their family) cannot participate on a pre-tax basis in a Section 125 plan

Type: ☐ **Full-time** ☐ **Part-time** _____**hrs/week**

Payroll ☐ **Monthly** ☐ **Semi-monthly (24 times/yr)** ☐ **Bi-weekly (26 times/yr)** ☐ **Weekly** ☐ **Other** _____

ELECTION AGREEMENT. I agree to the terms in the Plan document of the Employer Flexible Benefits Plan. I understand that an amount equal to my annual election, divided by the number of remaining pay periods in the Plan Year, will be deducted from each of my paychecks to pay for the coverages.

HFSA

HEALTH FSA – for reimbursement of my family's eligible Medical Care Expenses. Annual Minimum is $480, while Annual Maximum is $1,500.

Effective 04/01/2017, Total Plan Year **Payroll** Election: _**$**_____ which = __**$**_____**X** _____**remaining pay periods**

I understand that my election of a Health FSA may make me and my spouse ineligible for contributing to a Health Savings Account (HSA).

DEBIT CARD USAGE – you must read and sign the below EACH YEAR IF you are using the benefit debit card for the plan year. If you already have a card, elections for new plan years are placed on the same card so a new card is not issued each year.

The card will only be used to purchase eligible medical care under IRS Code 213(d) and expenses will not have been reimbursed nor will I seek reimbursement elsewhere. ***Participants should obtain all relevant documentation in case requested, i.e. keep all receipts and Explanations of Benefits (EOBs).*** *Participant must immediately report any loss or fraudulent use of the card. Otherwise participant may lose those funds.*

Signature (REQUIRED EACH YEAR if using benefits card):_____ **Date:** _____

E-mail address (system sends any card swipe documentation requests here):_____
(Reports and documentation requests show the date of service and the vendor name, i.e. 'Sloan Cancer Center', 'Walgreens')

NOTE – Complete the below ONLY if you have not provided it in the past since previously active dependent cards are applicable for all plan years.
List extra NEW Child/Spouse cardholder's Name, Social Security Number, Date of Birth, and Relation:_____

DIRECT DEPOSIT

NOTE – Complete the below bank information ONLY if you are a first time enrollee with BenefitsAssist, inc. or if the information is changed

If you wish to receive FSA reimbursements via direct deposit provide the following information OR attach a voided check:

Bank name: _____ **Name on account:** _____

ACH Routing Number (9 digits): _____ **Account Number:** _____ **Type:** ☐**Checking** ☐**Savings**

Authorization: I hereby authorize BenefitsAssist, inc. to deposit any amounts owed me by initiating credits to my account at the financial institution (hereinafter BANK) indicated above. I authorize BenefitsAssist, inc. to initiate any necessary debit entries and adjustments for any credits made in error. This authorization is to remain in full force and effect until BenefitsAssist, inc. and BANK have received written notice from me of its termination.

BenefitsAssist, inc. will charge a $25 fee for each rejected transaction.

Signature:_____ **Date:** _____

I understand I cannot change or revoke this Agreement prior to the next plan year, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event. Such changes must be submitted within 30 days of the event.

- Elections reduce salary for Social Security tax and any benefit based on taxable salary thus Social Security benefits may be lowered
- Unused amounts remaining in my Health FSA are forfeited
- General claims information such as date of service and category of service, i.e. 'Medical', is shown on Employer reports
- **Claims filing deadline is the earlier of 90 days after termination or 90 days after plan year end**

I agree to the terms of the Plan Document and SPD and to any applicable certifications set forth in this Agreement. Agreed to by:

Employee Signature _____ Date _____

→SUBMIT THIS FORM TO YOUR HUMAN RESOURCES OFFICE AND ASK THEM TO FORWARD TO BENEFITSASSIST, INC.

Print Form ***Submit Form*** ***Reset Form***

P.O. Box 31823 • Knoxville, Tennessee 37930-1823 • (865) 769-2800 • (888) 588-3650 fax • Flex@BenefitsAssist.net