FLEXIBLE BENEFITS ENROLLMENT/REVISION

Plan Year: January 1, 2020 through December 31, 2020

INSTRUCTIONS: *Complete this Enrollment Form if you wish to participate in **any** portion of the flexible benefit plan. You may elect to participate in one or any combination of the benefits outlined below. Return the completed forms to your in-house Benefits Administrator. Pension Dynamics will set up your account within two (2) business days after receiving the completed forms from your employer. After your account is set up, please go to www.pensiondynamics.com and log in to your account per the instructions included in your plan handbook. If you do not have a copy of the handbook for this benefit please contact your in-house Benefits Administrator or Pension Dynamics.*

Plan Name: _____

Example "ABC Company Flexible Benefits Plan" If you are unsure about your Plan Name please contact your human resources or benefits department.

SECTION 1. EMPLOYEE INFORMATION *(all fields in this section are required)*

Name	Social Security Number	Date of Birth	Male or Female Gender *(circle)*

Address _____ Personal E-mail Address _____

City _____ State _____ Zip Code _____ Phone Number _____

SECTION 2. DEPENDENT INFORMATION *(including spouse; if more space is needed, please attach a separate sheet)*

Full Name	Relationship	Gender	Date of Birth

SECTION 3. ENROLLMENT TYPE

☐ Open Enrollment ☐ Qualifying Event: _____ Date of Qualifying Event ☐ New Hire: _____ Date of Hire _____ Date of First Contribution

SECTION 4. PLAN PARTICIPATION *I authorize my employer to reduce my salary by the amounts indicated below.*

☒ Company Sponsored Insurance Premiums

I authorize my employer to reduce my salary on a pre-tax basis to pay for my share of the premium for those Health Insurance benefits in which I have enrolled via separate benefit enrollment form(s).

☐ Health Reimbursement Account *(annual maximum of $2,750 each plan year)*

This includes all eligible health-related expenses not covered by my health insurance or any other benefit plan for me and my dependents. *This account does NOT cover any type of Insurance Premiums.*

I elect $ _____ as my ANNUAL Health Reimbursement election for 2020. ☐ Waive Carry Over *(if applicable)*

☐ If available, I would like to limit my FSA to be compatible with the HSA my family currently participates in *(for more information consult your benefit plan handbook).*

☐ Dependent Daycare Account

If you are single, or married and file a joint return, *you may not have more than $5,000 in this type of account per calendar year. This limit is reduced to* $2,500 if you are married and file a separate return. Only dependent children under age 13 (unless physically or mentally handicapped) and/or a dependent adult requiring daycare qualify. Care must be for the hours when you and your spouse (if any) are at work.

I elect $ _____ as my ANNUAL Dependent Daycare election for 2020.

SECTION 5. QUALIFYING EVENT *(skip if not applicable)*

Note: Changes in elections due to a qualifying event must be made within 30 days of the event date.

☐ Family Status Change

☐ Marriage ☐ Divorce ☐ Legal Separation ☐ Death of Spouse

☐ Addition of dependent(s) to coverage ☐ Loss of dependent(s) from coverage

Full Name	Relationship	Gender	Date of Birth

☐ Employment Status Change

☐ Significant change in employment status (please explain)

☐ Significant change in spouse's employment status (please explain)

☐ Significant change in my spouse's company sponsored benefits

☐ Significant change to cost of dependent daycare expenses

Explanation

Your change in status may qualify you to change your coverage election. Changes cannot be retroactive, must be in accordance with your family status change, and are subject to approval. Please indicate the change in your Coverage Elections below. Election amounts cannot be reduced below the amount already contributed.

Election Change _____ Payroll Effective Date

Miscellaneous Health New Election Amount $ _____ Annual

Dependent Daycare New Election Amount $ _____ Annual

Note: Any change to your election will mean a new period of coverage. This means if you change your election amount to zero ($0.00) per pay period, your coverage will be terminated and qualifying expenses if incurred after the date of your last contribution are **not eligible** for reimbursement.

☐ Leave of Absence *(select below)* _____ Date Leave Commences

☐ Have additional deductions taken **prior** to the commencement of my leave of absence sufficient to make up for the anticipated missed deductions.

☐ Have additional deductions taken **upon returning** from my leave of absence sufficient to make up for the missed deductions.

☐ Continue contributing to the spending accounts on an after-tax basis.

☐ **Terminate my participation** in the spending account portion of the plan as of the date my leave of absence commences, with the understanding that my expenses incurred during my leave will not be reimbursable and that no further payroll deductions will be taken for the remainder of the year.

☐ Return from Leave of Absence

Having previously elected to terminate my participation in the spending account portion of the plan upon commencement of my leave of absence, I would now like to be reinstated in the plan and understand that this election is from this point forward and that services provided to me during my leave of absence will not be eligible for reimbursement. I further understand that my available annual election will be prorated for the period during my leave for which no deductions were taken and reduced by any reimbursements that have been previously paid.

SECTION 6. PARTICIPANT AUTHORIZATION

I understand that:

- The plan handbook has more detailed information and I can request said handbook from either my in-house Benefits Administrator.
- I cannot change this election during the plan year unless I undergo a change in family status as discussed in the SPD and benefit handbook. Upon the occurrence of a qualifying event, I will need to complete a new form and submit it to my Human Resources Department within 30 days of that event.
- I have 90 days from the end of the plan year to submit any claims incurred in the plan year. Any unused funds left in my account at the end of the plan year are forfeited unless my employer offers Carry Over as discussed in the SPD and benefit handbook.
- If I terminate my employment, whether voluntarily or involuntarily, and do not elect to COBRA my Health Reimbursement Account, I can only submit expenses incurred prior to my termination date
- My Social Security Benefits/Disability may be affected by this election.
- I cannot claim a tax credit for any expenses paid for by this Plan.
- If I elect to participate in the Dependent Daycare Account I must file IRS Form 2441 with my tax return.
- This election replaces any prior elections and will terminate at the end of the plan year, or if this plan is terminated.
- If I or my spouse has contributions being made into an HSA I understand I am not able to participate in a full Health Reimbursement Account.
- If I meet the definition of a highly compensated and/or Key Employee, I may be unable to participate or my contribution may be retuned as taxable compensation due to IRS Non-Discrimination rules.

_____ _____

Employee Signature Date