



FLEXIBLE BENEFITS PLAN ELECTION FORM & COMPENSATION REDIRECTION AGREEMENT

ALL FIELDS ARE REQUIRED – PLEASE PRINT

NAME OF YOUR EMPLOYER: _____

PLAN YEAR DATES: _____ To _____

SOCIAL SECURITY NUMBER: _____

NAME ON CARD: _____
21 characters maximum including spaces

HOME ADDRESS:
Street _____

City _____ State _____ Zip Code _____

NAME ON 2nd CARD: _____
21 characters maximum including spaces

EMAIL ADDRESS: _____

DATE OF BIRTH (mm/dd/yy): _____ HOME PHONE: _____

MOTHER'S MAIDEN NAME (security purposes only): _____

ELECTION OF BENEFITS

In accordance with my rights under the Plan, I elect the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the Plan Year designated above.

▶ I receive my paychecks: Weekly(52) Biweekly(26) Semimonthly(24) Monthly(12)

FLEXIBLE SPENDING ACCOUNT OPTIONS	PAY PERIOD ELECTION AMOUNT <small>(Plan Year Amt ÷ # Pay Periods)</small>	PLAN YEAR ELECTION AMOUNT <small>(Pay Period Amt x # Pay Periods)</small>
1. Medical Care Reimbursement Account <i>(maximum \$ _____ per plan year)</i>	\$ _____	\$ _____
2. Dependent/Child Care Reimbursement Account <i>(maximum \$5,000 per tax year)</i>	\$ _____	\$ _____

After completing your election above, **read the back of this form carefully.** Please **sign and date** the reverse side of the **form if you want to participate** in any of the **spending account options** above.

EMPLOYER USE ONLY – PLEASE COMPLETE BEFORE SENDING A COPY TO ADMIN AMERICA

FIRST DEDUCTION DATE: _____ TOTAL NUMBER OF DEDUCTIONS: _____

MEDICAL CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying health care expenses**" as described in the **Summary Plan Description**.
- **I cannot change or revoke my Medical Care Reimbursement Account at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description**.

DEPENDENT CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying dependent care expenses**" as described in the **Summary Plan Description**.
- **I cannot change or revoke my Dependent Care Reimbursement Account at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description**.

OTHER IMPORTANT TERMS AND CONDITIONS

I understand that:

- Before the first day of each plan year I will be offered the opportunity to make my benefit election for the new year. **If I do NOT complete and return a new election form prior to the first day of the new year,** I will be treated as having elected NOT to participate in reimbursement accounts effective for the new plan year.
- **I understand that my Employer has chosen to issue me a mySourceCard™ MasterCard® benefits debit card for use with my flexible spending account and that I may request an additional Card for my spouse.** I also understand that I am required to submit appropriate proof of qualified expenses within 45 days of the date the expense is incurred.
- **I am solely responsible for notifying the Employer if I have reason to believe that an expense for which I have obtained reimbursement is not a qualifying expense. I understand that, upon notification, I must immediately re-pay my Employer for the amount of any non-qualified reimbursement and that my Card may be immediately suspended or revoked for failure to comply.**
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it is required in order to satisfy federal law.
- **Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year.**
- My Social Security benefits may be slightly reduced as a result of my election.

mySourceCard™ Enrollment Agreement

As a participant in one or more of your Employer Plans, you will receive a mySourceCard™ MasterCard® benefits debit card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the mySourceCard™ MasterCard®.

You understand that the mySourceCard™ MasterCard® is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the mySourceCard™ MasterCard® at any merchant, bank or ATM. You understand that the mySourceCard™ MasterCard® is to be used **exclusively** for Qualified Expenses as defined by the plan(s) in which you participate. If the mySourceCard™ MasterCard® is issued pursuant to Employer Plans and you use the benefits debit card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the mySourceCard™ MasterCard® and agree to submit copies of these documents attached to a signed claim form for review by Admin America, the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

This agreement (1) is subject to the terms of the employer's Flexible Benefits Plan, Medical Care Reimbursement Plan and/or Dependent Care Assistance Plan in effect as amended from time to time, (2) shall be governed by and construed in accordance with applicable laws, (3) shall take effect as a sealed instrument under applicable laws, and (4) to the extent allowed by law, revokes any prior election and compensation redirection agreement relating to such plan(s) for the corresponding Plan Year.

Employee's Signature: _____ **Date:** _____

For Official Use Only

Admin America Initials:	Receive Date:	Process Date:
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For Official Use Only

DCSI Rep Initials:	Receive Date:	Process Date:
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