



FLEXIBLE BENEFITS PLAN ELECTION FORM & COMPENSATION REDIRECTION AGREEMENT

NAME OF YOUR EMPLOYER: _____

PLAN YEAR DATES: _____ TO _____

SOCIAL SECURITY NUMBER: _____

NAME: First _____ Middle Initial _____
Last _____

HOME ADDRESS:
Street _____
City _____ State _____ Zip Code _____

EMAIL ADDRESS: _____

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 need a **new** "mbi Flex MasterCard" because: I am new to this Plan I cannot find my other card(s)

▶▶ I need a **new** "mbi Flex MasterCard" issued in my spouse's name below: YES NO

Spouse's Name (Print like you want it on the Flex Card): _____

Spouse's Social Security Number: _____

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

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

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 "mbi Flex MasterCard's" 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 30 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.

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:** _____

Accepted and agreed to by the Employer's Authorized Representative.

By: _____ **Date:** _____