FLEX source, LLC.
Flexible Benefits Specialists

Election Form / Salary Reduction Agreement
Flexible Spending Accounts

Employee Information

Add _____   Change* _____   Employee Termination* _____
(*Must provide reason on back of form and must be authorized by employer)

Company/Client Name

_____

Employee Name   Key _____ Highly Compensated _____   Date of Hire

_____

Social Security Number   Birthdate   Employee Phone Number
                                                        (   )
_____

Street Address   City   State   Zip

_____

Number of Paychecks Received Annually

Weekly (52x) _____   Bi-Weekly (26x) _____   Semi-Monthly (24x) _____   Monthly (12x) _____   Other _____

	$/Pay Period		# of Pay Periods		Annual Election
_____ Medical/Dental Reimbursement	_____	*	_____	=	_____
_____ Dependent Care Reimbursement	_____	*	_____	=	_____

* In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning
____/____/____ and ending ____/____/____ . Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. As a participant, I understand that:

- I cannot change or revoke this agreement at any date prior to the next plan year unless I have a change in status as set forth in the Adoption Agreement and Summary Plan Description. Prior to my next plan year I will be offered the opportunity to change my benefit election for the following year.
- My pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that change.
- The plan administrator may change the amount of my pay reduction or otherwise modify this agreement if he believes it is to satisfy provisions of the Internal Revenue Code.

• The amount of my compensation reduction will be credited to the appropriate reimbursement account on my employer's books for payment of eligible expenses incurred within the plan year.

• Reimbursement will be available only for qualifying expenses as described on the attached form. I agree to notify the employer if I have a reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the employer for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive on a non-qualifying expense.

• If the amount in my reimbursement account at the end of the year exceeds the amount of my eligible expenses for the plan year, I will forfeit the excess amount.

The pay reduction will not be effective for any pay period that begins before you have signed this form and returned it to the Plan Administrator.

Changes / Terminations

Date of event: _____/_____/_____

First paycheck date that change will be processed: _____/_____/_____

_____ Change in Employment Status of Participant or Participant's Spouse
_____ Marriage/Divorce of Participant
_____ Adoption, Birth or Death of Child or Dependent
_____ Coming of Age of Child or Dependent
_____ FMLA (Family Medical Leave) Leave of Absence
_____ Participant Beginning or Ending Adoption Proceedings
_____ Medicare or Medicaid Entitlement
_____ HIPAA Special Enrollments
_____ Judgement, Decrees or Orders
_____ COBRA Qualifying Event

_____   _____
Signature of Employee   Date

_____   _____
Signature of Employer   Date

Return This Form To:
FlexSource, LLC
P.O. Box 828
Elmhurst, IL 60126

REMINDER: Please advise your payroll department of these employee deductions.