



## FLEXIBLE SPENDING ACCOUNTS & COMMUTER - ELECTION FORM

*You must complete and return this form. Please print.*

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Email: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employee ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Employer: \_\_\_\_\_ Division: \_\_\_\_\_

I hereby authorize my employer to reduce my salary (on a pre-tax basis) by the amount necessary to pay for the coverages indicated below. I understand that I must use all my flexible Benefit contributions or forfeit them.

**Health Flexible Spending Account (FSA):**  
(IRS Maximum Annual Election is \$3,200)  Yes  No \$ \_\_\_\_\_  
ANNUAL AMOUNT

**Dependent Care Assistance Plan (DCAP):**  
(IRS Maximum Annual Election is \$5,000)  Yes  No \$ \_\_\_\_\_  
ANNUAL AMOUNT

**Commuter - Qualified Parking:**  
(IRS Maximum Monthly Contribution is \$315)  Yes  No \$ \_\_\_\_\_  
MONTHLY AMOUNT

**Commuter - Transit & Vanpooling:**  
(IRS Maximum Monthly Contribution is \$315)  Yes  No \$ \_\_\_\_\_  
MONTHLY AMOUNT

**The IRS does not allow cash reimbursement for Transit passes.**

**Please complete the following dependent information and indicate if requesting a debit card.  
Dependent cards can only be issued for the Health FSA or Dependent Care FSA, not for Commuter Accounts.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship:  Spouse  Dependent Student:  Yes  No Card:  Yes  No

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship:  Spouse  Dependent Student:  Yes  No Card:  Yes  No

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship:  Spouse  Dependent Student:  Yes  No Card:  Yes  No

Your election to participate in any pre-tax eligible benefits will constitute an election under your employers Section 125 Cafeteria Plan and any contributions you are required to make under any such plan will be deducted from your (examples: Group Health, Dental and Vision Plan) salary on a pre-tax basis unless you requested otherwise.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Authorization

\_\_\_\_\_  
Date

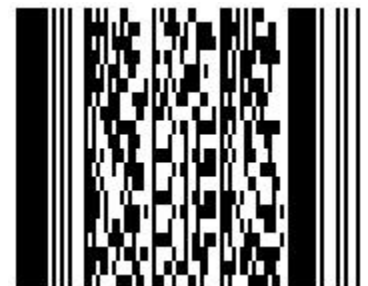
**EMPLOYER – PLEASE COMPLETE**

Benefit Effective Date \_\_\_\_\_

Pay Date for 1<sup>st</sup> Contribution \_\_\_\_\_ Number of Pay Periods \_\_\_\_\_

Fax: 877-723-0147 or email: [processing@amben.com](mailto:processing@amben.com)

Mail: American Benefits Group • PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539



In signing the reverse of this form, I understand and agree to the following:

The Company and I hereby agree that my cash compensation will be reduced by the amounts I have elected on this form on a per pay-period basis during the plan year (or during such portion of the year as remains after the date of this agreement).

**THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE COMPANY'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).**

I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a status change event (including marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, change in job schedule of participant or spouse, dependent satisfying or ceasing to satisfy dependent eligibility requirements, entitlement to Medicare or Medicaid, judgment, decree or court order or such other events as the Plan Administrator determines will permit a change or revocation of an election).

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

The amount of my compensation reduction during the year will be credited to an insurance, medical reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed for qualified expenses incurred during the plan year. If I terminate employment, I will only be reimbursed for expenses incurred prior to my termination date unless I qualify for, and elect COBRA coverage.

My Social Security benefits may be slightly reduced as a result of reduced taxable income due to my election(s).

If required contributions for elected benefits are increased or decreased while this agreement remains in effect, the compensation reduction will automatically be adjusted to reflect that increase or decrease.

**Health Flexible Spending Account (FSA) Reimbursement** Medical Reimbursement will be available only for "qualifying medical care expenses" which are those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e., premiums for health insurance cannot be reimbursed from your Medical Expense Reimbursement Account). I agree to notify the company if there is reason to believe that any expense for which reimbursement has been obtained is not a qualifying expense. I also agree to indemnify and reimburse the company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

This agreement will automatically terminate if the Plan is terminated or discontinued.

**Dependent Care Assistance Plan (DCAP)** will be available only for "qualifying dependent care expenses" as described below. I agree to notify the company if there is reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense, I also agree to indemnify and reimburse the company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

I agree to provide the Plan Administrator with the name, address, and taxpayer identification number of each dependent care service provider.

**Qualifying Dependent Care Expenses:**

1. The expenses are incurred for services rendered after the date of this election and during the plan-year to which it applies.
2. Each individual for whom you incur the expenses is (a) a dependent under the age 13 whom you are entitled to claim as a dependent\* on your federal income tax return or (b) a spouse or other tax dependent\* who is physically or mentally incapable of caring for himself or herself.  
  
\*or a child or other dependent under age 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2(a) above, or who regularly spends at least 8 hours a day in your household.
5. The expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the Facility), which complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom you or your spouse are entitled to a personal tax exemption.
8. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the least of the following limits: (a) The maximum allowed under the Plan. (b) \$5,000 if you are filing a joint tax return or \$2,500 if separate returns are filed. (c) Your taxable compensation (after all compensation reduction elections). (d) If you are married, your spouse's actual or deemed earned income.

**Qualified Parking**—Expenses for parking at or near the employer's business premises or parking at or near a location from which an employee commutes to work by mass transit, vanpooling, carpool, etc.

**Transit & Vanpooling**—Expenses for any pass, fare card or similar item that entitles the employee to transportation on a mass transit system to and from work or for the cost of transportation between the employee's place of residence and place of employment in a commuter vehicle that has a seating capacity of 6 persons or more (not including the driver) where at least 80% of the mileage used for the year is for the purpose of transporting employees to their place of employment.