

Participation Form for the

elkin&
ASSOCIATES

Flexible Benefits Plan

Employer:	Social Security #: - -		
Last Name:	First Name:	Birthdate: / /	
Mailing Address:			
City:	State:	Zip:	
Daytime Phone: () -	E-mail: @		
Pay Frequency: <input type="checkbox"/> 52 Pays (Weekly) <input type="checkbox"/> 26 Pays (Bi-Weekly) <input type="checkbox"/> 24 Pays (Semi-Monthly) <input type="checkbox"/> 12 Pays (Monthly)	Effective Date:		

All enrollment elections made on this form are effective for the plan year beginning _____ and ending _____. Certain minimum and maximum contributions amounts, specific eligibility requirements and other rules apply; see your **Summary Plan Description** for complete details. Return the completed form to your Human Resources Department. In the event your employer elects internet or other electronic enrollment process you will be provided additional instructions regarding the enrollment process.

OPTION I: UNREIMBURSED MEDICAL SPENDING ACCOUNT

I elect to contribute \$_____ (before taxes) per pay period, which is \$_____ per plan year, to fund the following type of spending account for reimbursement of qualified healthcare expenses which are not covered under any other insurance plan. Select one of the following:

- General Purpose FSA Limited Benefit FSA
 Employee Only FSA Employee + Child FSA Post Deductible FSA

I decline to participate in this option for this plan year.

OPTION II: DEPENDENT CARE (DAYCARE) ASSISTANCE PLAN

I elect to contribute \$_____ (before taxes) per pay period, which is \$_____ per plan year, to fund my account for reimbursement of qualified dependent care expenses. I understand that I will need to complete Form 2441 with my annual tax return.

I decline to participate in this option for this plan year.

OPTION III: PREMIUM CONVERSION PLAN

I have enrolled in certain employer-sponsored insurance benefits. I understand that my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my taxable income will automatically be adjusted to reflect that increase or decrease.

I decline to participate in this option for this plan year.

SALARY REDUCTION AGREEMENT AND SIGNATURE:

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I can only change my election in the event of a "change in status" event as provided by the IRS as long as I notify my employer within 30 days of the event. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. I hereby affirm that any enrollments or expenses submitted on behalf of my family members will be for individuals who meet the definition of dependent under IRC §152 as provided in the Working Families Tax Relief Act of 2004. I hereby acknowledge that I have access to a print copy of the Summary Plan Description.

Employee Signature:	Date:
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