Flex Election Form

Name of Company/Group: **CARROLL COUNTY BOARD OF EDUCATION**
Last Name: _____ **Social Security Number:** _____
First Name: _____ **Telephone #:** _____
Employee Home Address: _____
Email Address: _____
Hire Date: _____ Effective Date of Elections: _____
Plan Year: January 1, 2014 thru December 31, 2014 Location: _____

Key Employee:	Yes:	_____	No:	_____
Officer:	Yes:	_____	No:	_____
Highly Compensated:	Yes:	_____	No:	_____

DO NOT COMPLETE THIS AREA. IT IS TO BE COMPLETED BY HUMAN RESOURCES.

Please note any changes made on this form will only affect your pre-tax deductions. Any changes (additions/deletions) to your insurance must be made through the insurance department of Carroll County Board of Education.

Benefit Information

Benefit Description	Cost	Current Monthly Employee Deduction	Future Monthly Employee Deduction	Decline
Dependent Day Care Accounts (DC) **(annual benefit limit of $5,000.00)**		$_____	$_____	_____
Medical Expense Accounts (ME) **(annual benefit limit of $2,500.00)**		$_____	$_____	_____
Monthly Administrative Fee for Flex Accounts			**$ 1.50**	

Enrollment Instructions

Review the benefits listed above. The Company pays for some of the benefits and you, the employee, pay for some. If you wish to participate in these benefits, enter the amount to be deducted from your pay on a monthly basis in the space provided to the right of the coverage(s) desired, in the column titled "Monthly Employee Deduction". Some of these benefits such as dependent day care, are completely voluntary. You may choose to have any amount deducted from your paycheck and deposited in a Flexible Spending Account up to the limits set by law and/or your employer. If you do not wish to participate or want your premium-only account deductions deducted from your pay on an "after-tax" basis, put your initials on the decline line by the associated benefit(s). ***Either way, read this document thoroughly, then sign and date the back of the form***.

I understand that:

I elect to receive the above coverage(s) under the Cafeteria Plan. I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the 12 month period known as the Plan Year defined in the Plan document (or during such portion of the year as remains after the date of this agreement), unless I have a change in status (marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of my spouse's employment, change in my or my spouse's employment status from full-time to part-time or part-time to full-time, my spouse or I taking an unpaid leave of absence), and such other events as the Plan Administrator determines will permit a change or revocation of an election. The requested revision in benefits must be consistent with the change. Each year, prior to the end of the Plan Year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my current premium only plan benefit coverage(s) then in effect for the new Plan Year. ***This will not apply to the flexible spending account elections. I must make and/or renew these elections each Plan Year. If I do not make and/or renew my flexible spending account election(s) for the new Plan Year, I will receive the cash compensation in effect for the new Plan Year.***

If my ***required*** contributions for the elected premium-only benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease. The Plan Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the Cafeteria Plan if they believe it advisable in order to satisfy certain provisions of the Internal Revenue Code. The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

If electing the medical reimbursement account:

1. Reimbursements will be available only for "qualifying medical care expenses". Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have 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 Employer 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 additional tax actually owed by me.
2. This section of the agreement will automatically terminate if the Plan is terminated or discontinued.
3. If I cease my employment with the Employer, my participation in the Plan will cease. No further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursements for claims incurred prior to my date of termination.
4. I cannot seek reimbursement from this account for a medical expense that I intend on taking as a deduction or credit on my tax return.

If electing the dependent daycare account:

1. Reimbursements will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description. I agree to notify the Employer if I have 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 Employer 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 additional tax actually owed by me.
2. I agree to provide the Administrator with a statement from the service provider that includes the amount of expense incurred, dates of service this expense covers, the name, address, and tax payer identification number of the service provider.
3. This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.
4. I will only be reimbursed for amounts up to the balance in my account at the time of my request.
5. I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

I understand that my unused balance in the reimbursement accounts, if any, at the end of the plan year will be forfeited by me back to my employer, after the 2 & ½ month grace period (ends March 15th of each plan year) and the three-(3) month claims processing run-out period (ends June 15th of each plan year).

The employer and I agree that my cash compensation will be reduced by the amounts set forth above during the Plan Year (or during such portion of the year as remains after the date of this agreement). I understand that this will lower my gross pay, consequently, my tax base, and my Social Security Base.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, 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.

Employee's Signature	Date Signed
Employer's Representative	Date Signed

Enrollment form must be signed, dated and returned to Insurance Department before the end of the Open Enrollment Period.