healthgram

For Office Use Only
Department #_____
Employee #_____

FLEXIBLE BENEFITS ELECTION FORM for 2019

Plan Sponsor - **Western North Carolina Conference**	**Date Employed** **/ /**
Employee Name Last First MI	**Member ID Number (found on ID card)**
Employee's Address Street City State Zip Code	
Birth Date **/ /**	**Sex** ☐ **Male** ☐ **Female**
Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated**	
Home Phone **( ) -**	
Are you covered by any other benefit/insurance plan? ☐ **Yes** ☐ **No**	**Are any of your dependents covered by any other benefit/insurance plan?** ☐ **Yes** ☐ **No**

List Dependents

	Last	First	MI	Sex	DOB	Social Security Number
Spouse						
Dep.						
Dep.						
Dep.						
Dep.						
Dep.						

Pursuant to my Employer's Flexible Benefits Plan, I elect to have my salary reduced by the total pre-tax amount specified below. I authorize my Employer to apply that amount toward those plan benefits listed on this form with the total to be distributed among each benefit as shown.

ENTER AMOUNT

1. FSA Plan (Medical Expense Reimbursement)
   Annual Pledge
   $ _____
   To be deducted at each pay period
   (Divide annual pledge by number of pay periods.) $_____

ENTER AMOUNT

2. Dependent Care Reimbursement
   Annual Pledge
   $ _____
   To be deducted at each pay period
   (Divide annual pledge by number of pay periods.) $_____

I UNDERSTAND AND AGREE THAT:

1. The benefit options I have elected will remain in force through the Plan year, unless I have a change in family status. I understand that if I have such a family status change, I must report it to Human Resources in writing within 60 days of the event and that I may change the amount of my reallocation at such time consistent with the family status change.
2. Any funds remaining in my reimbursement account in excess of the allowed carry-over of up to $500.00 at the end of the plan year will be forfeited by IRS regulations.
3. My Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my allocations in accordance with the plan if my Employer, in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue Code or the regulations thereunder.
4. If my employment terminates for any reason, I understand expenses must be incurred and submitted within the time frames set out in the Plan.
5. I understand the procedures for submitting receipts and any receipt I submit must be for any eligible expense incurred during the applicable plan year.
6. Before the first day of each Plan year. I will be offered the opportunity to modify my elections for the following Plan year.

☐ **I do not wish to join the Flexible Benefits Plan.**

_____ ____/____/_____ _____
Employee's Signature Date Email Address