PAYCHEX

Election Form/Compensation Reduction Agreement
Flexible Spending Account

SECTION 1 - EMPLOYEE INFORMATION (print)

Office/Client Number _____

Company Name (REQUIRED) _____ Employee Phone Number (_____) _____ - _____

Employee Name (REQUIRED) _____ Social Security Number (LAST 4 DIGITS REQUIRED) _____

Address (REQUIRED) _____ City (REQUIRED) _____ State (REQUIRED) _____

ZIP Code (REQUIRED) _____ Email Address _____ Date of Birth (REQUIRED) _____

SECTION 2 - ENROLLMENT OPTIONS (select one)

☐ **New Enrollment or Annual Enrollment Change**
Date of Hire _____ / _____ / _____

Notes: New enrollments will be effective on the first of the month following the date eligibility requirements are met. Your maximum annual election is determined based on the month you enter the plan.

The annual maximum contribution for the remainder of 2015 is $400 for November start dates and $200 for December start dates.

Starting 1/1/2016, the annual maximum contributions will be the limit established by the IRS for the plan year. Participants will be allowed to elect up to 1/12 of the maximum for each month remaining in the year.

Example: If participant enters Plan May 1, and the IRS maximum for 2016 is $2,550, then since there are 8 months remaining in 2016 a maximum election of $1,700 ($2,550 / 12 * 8) is allowed.

Annual enrollment changes will be effective on the first payroll following January 1st.

☐ **Debit Card (if applicable)**
Dependent's Name (if applicable) _____

☐ **Change In Status**
Date of Event _____ / _____ / _____

Note: If Change in Status has occurred, changes in enrollment and supporting documentation must be submitted to Paychex Business Solutions, LLC (PBS) within 30 days of the event.

- ☐ Dependent care cost provider changes
- ☐ Dependent satisfies or ceases to satisfy dependent eligibility requirements
- ☐ Birth/Death of spouse or dependent, adoption or placement for adoption
- ☐ Spouse's employment commenced/terminated
- ☐ Status change from full-time to part-time or vice versa by employee or spouse*
- ☐ Eligibility or Ineligibility of Medicare/Medicaid
- ☐ Change from salaried to hourly or vice versa*
- ☐ Marriage/Divorce/Legal Separation
- ☐ Unpaid leave of absence by employee or spouse
- ☐ Return from unpaid leave of absence by employee or spouse
- ☐ Termination of employment (you will be de-enrolled)

* These changes are allowable only if eligibility is affected.

SECTION 3 - ENROLLMENT ELECTION

To calculate your per-pay-period deduction, divide your annual amount by the number of pay periods remaining in the plan year. Your maximum annual election allowed for Unreimbursed Medical Care is outlined in the Notes listed in Section 2 based on the month that you are eligible to enter the plan. If the annual election that you elect above is greater than the maximum annual election allowed, you will be enrolled at the maximum allowable.

☐ Annual Unreimbursed Medical Care Election $ _____
Maximum Annual Election Table

☐ Annual Dependent Care Election $ _____
Maximum $5,000.00

DCA is issued for custodial care of a dependent, not for medical expenses of a dependent.

Note: Expenses incurred by or on behalf of a domestic partner and/or a domestic partner's child are not reimbursable. If you are enrolled only in DCA, a debit card will not be issued. Dependent information is required to submit claims for services incurred by your dependent.

SECTION 4 - AUTHORIZATION

I hereby elect to participate in the Flexible Spending Account for the Plan Year ____ / ____ / ____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked. I cannot change or revoke this election at any date prior to the next plan year unless I experience a change in status (also referred to as a qualifying event). If, during my next enrollment period, I do not complete and return a new election form during my enrollment period, I will be treated as having elected to continue my employee election as set forth in this election form for the next plan year. As a participant, I understand that all guidelines regarding enrollment are set forth in the Summary Plan Description.

Reduction of Pay

- ❖ I understand that my pay will be reduced each pay period by the amount of my required contribution for the benefit option(s) I have elected until this agreement is amended or terminated. The reduction in my pay under this agreement will be in addition to any reductions under other agreements or benefit plans.
- ❖ I understand that my pay reduction will be automatically adjusted if my required contributions change while this agreement is in effect and that the plan administrator may change the amount of my pay reduction or otherwise modify this agreement if it is required to satisfy provisions of the Internal Revenue Code.

Reimbursements

- ❖ I understand that Paychex Business Solutions, LLC (PBS) will hold my contributions for payment of eligible expenses incurred within the Plan Year and that reimbursement will be available only for qualifying expenses.
- ❖ I agree to notify PBS if I believe that any expense for which I have received reimbursement is not a qualifying expense. I also agree to indemnify and reimburse PBS for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense.
- ❖ I understand that for the 2015 plan year I will forfeit any balances I have at the end of the year for which I have no eligible expenses to submit. Starting with the 2016 plan year, I will be allowed to carryover up to $500 of unused balance into the next plan year.
- ❖ I understand that beginning with the 2016 plan year reissuance of a replacement debit card is subject to a $5 fee.

FSA with an HSA

- ❖ If I have a Flexible Spending Account in conjunction with a Health Savings Account (HSA), I may only submit medical expenses under the Unreimbursed Medical portion of my Flexible Spending Account for dental, vision, and preventative care. My HSA may be used to pay for any remaining HSA-qualified medical expenses.

Employee Signature (REQUIRED) _____ Date (REQUIRED) ____ / ____ / ____

Access your Paychex Benefit Account (PBA) at www.paychexflex.com or through the Automated Phone System at 1-877-244-1771.
Mail or FAX to Paychex, Section 125 Department, 1175 John St, West Henrietta, NY 14586 – Fax – 585-389-7349.