



SOUTHERN TIER ENVIRONMENTS FOR LIVING, INC.
FLEXIBLE SPENDING ACCOUNT ELECTION FORM
December 1, 2014 – November 30, 2015

EMPLOYEE NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ DATE OF HIRE _____

MAILING ADDRESS _____

CITY, STATE, ZIP _____

DAYTIME PHONE _____ E-MAIL _____

MEDICAL CARE ACCOUNT

Note: Maximum allowed per plan year- \$2,500

My annual election is \$ _____, divided by _____ (number of pay periods per year) for a deduction of \$ _____ * per pay. Please deposit the funds into my Medical Care Reimbursement Account.

*Divide your annual election by the # of pay periods; or if you are a new participant mid-plan year, use the number of remaining pay periods for the plan year.

DEPENDENT CARE ACCOUNT (DAYCARE)

Per IRS Reg: Daycare expenses can only be reimbursed what has been deducted from your pay to processing date.

Note: Maximum allowed per family per plan year - \$5,000 or your spouse's earned income, whichever is less. Maximum allowed for married persons filing separately - \$2,500.

My annual election is \$ _____, divided by _____ (number of pay periods per year) for a deduction of \$ _____ * per pay. Please deposit the funds into my Dependent Care Reimbursement Account.

*Divide your annual election by the # of pay periods; or if you are a new participant mid-plan year, use the number of remaining pay periods for the plan year.

DEBIT CARD

A Beneflex debit card will automatically be ordered for you.

Please order a card for my spouse. Spouse name: _____ Birthdate: _____

When you are currently enrolled in Beneflex and have a debit card, *please keep the card to use from year to year.*

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, and termination of employment of spouse.)

I have read the enrollment materials explaining this benefit. I understand that my contributions to each account can only be used to reimburse eligible expenses under each account and that I forfeit any funds remaining in my account at the end of the plan period.

I further understand that social security benefits may be reduced since social security taxes are not paid on my contributions. I authorize payroll reductions as contributions to my health, and/or dependent care accounts as indicated above.

Signature _____ Date _____



