USBAFLEX

BENEFIT ELECTION FORM

EMPLOYEE INFORMATION

NAME (FIRST, MIDDLE, LAST):

SOCIAL SECURITY NUMBER:	EMPLOYER NAME: Piute School District

EMPLOYEE HOME ADDRESS:	CITY:	STATE:	ZIP CODE:

E-MAIL ADDRESS:	HIRE DATE(NEW EMPLOYEES ONLY):

PAY SCHEDULE:	☐ 10 month	☐ 11 month	☐ 12 month	☐ Other:

FSA/HSA PAYROLL DEDUCTION

PLAN YEAR: 9/1/13 TO 8/31/14

MEDICAL/HEALTH CARE FSA ELECTION

	Employee and dependent's out-of-pocket medical, dental and vision expenses.	PER PAY PERIOD	$
		TOTAL ANNUAL ELECTION	$
>	**CHECK HERE IF PARTICIPATING IN AN HSA. MEDICAL FSA WILL BE LIMITED PURPOSE, COVERING DENTAL AND VISION EXPENSES ONLY. (ENTER HSA CONTRIBUTION AMOUNT BELOW)** ☐ *$2500 annual maximum per participant.*		

DEPENDENT CARE FSA ELECTION

	Child or dependent care expenses (ex. day care) *$5000 annual maximum for single and married filing jointly, $2500 annual maximum for married filing separately.*	PER PAY PERIOD	$
		TOTAL ANNUAL ELECTION	$

HEALTH SAVINGS ACCOUNT ELECTION

	Annual maximums: 2013- self only $3250, family $6450; 2014- self only $3300, family $6550; Catch-up for age 55 and older add'l $1000	PER PAY PERIOD	$
		TOTAL ANNUAL ELECTION	$

TOTAL ANNUAL CONTRIBUTION	$

REIMBURSEMENT METHOD

>	**CONTACT YOUR EMPLOYER FOR AVAILABILITY. IF LEFT BLANK, REIMBURSEMENT CHECKS WILL BE ISSUED.**

AXISPLUS DEBIT CARD

☐	Complete the AxisPlus Card Enrollment Agreement

Please see reverse side for Salary Reduction Authorization and Acknowledgement, and POP (Premium Only Plan) deductions or to decline participation.

PREMIUM ONLY ACCOUNT PAYROLL DEDUCTION

>	DEDUCTIONS ARE PER PAY PERIOD (I.E., MONTHLY, BI-WEEKLY, ANNUALLY)	
I elect to participate in the Premium Only account for the upcoming plan period.	GROUP MEDICAL INSURANCE PREMIUM	$
	GROUP DENTAL INSURANCE PREMIUM	$
	ADMINISTRATION FEE	$
	OTHER	$
TOTAL PREMIUM DEDUCTION		**$**

SALARY REDUCTION AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that pretax deductions to my Health and/or Dependent Care FSA can only be used to reimburse eligible expenses and that any remaining funds at the end of the plan year will be forfeited. This election form will remain in effect and cannot be revoked or changed during the plan year, unless consistent with the qualifying events allowed under this Plan. I have read the Summary Plan Description (SPD) provided to me by my employer.

HEATH SAVINGS ACCOUNTS:

I certify that I am an "Eligible Individual" as defined by the Code and do herby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code (For more information about HSA eligibility requirements, see IRS Publication 969.). I further understand that I am responsible for all contributions made to my HSA. My Social Security may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll reductions as contributions to my Flexible Spending Accounts and Health Savings Account as indicated above. Please see your employer or HR contact for administration fee rates, if applicable.

TO AUTHORIZE PARTICIPATION:

I hereby certify the above information to be correct and true and choose to participate.

SIGNATURE: DATE:

TO DECLINE PARTICIPATION:

The benefits of the plan have been thoroughly explained to me, but I choose not to participate.

Signature Date