AXISPLUS BENEFITS

BENEFIT ELECTION FORM

EMPLOYEE INFORMATION

NAME (FIRST, MIDDLE, LAST):

SOCIAL SECURITY NUMBER:	EMPLOYER NAME: Garfield School District

EMPLOYEE HOME ADDRESS:	CITY:	STATE:	ZIP CODE:

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

FSA PAYROLL DEDUCTION

MEDICAL/HEALTH CARE FSA ELECTION

Employee and dependent's out-of-pocket medical, dental and vision expenses.

$2550 annual maximum per participant

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.** ☐

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	$

TOTAL ANNUAL CONTRIBUTION $

REIMBURSEMENT METHOD

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

☐ AxisPlus Debit Card (Please print clearly)

NAME ON 1ST CARD:

NAME ON 2ND CARD:	RELATIONSHIP TO EMPLOYEE:

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 $

Please see reverse side for Salary Reduction Authorization and Acknowledgement or to decline participation.

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. I authorize payroll reductions as contributions to my Flexible Spending Accounts and/or Premium Only Account as indicated above. Please see your employer or HR contact for administration fee rates, if applicable.

By signing this agreement, I authorize the Plan Service Provider (PSP) to initiate credit entries to the account indicated above for the purpose of reimbursements from my FSA account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error. I understand that I am responsible to notify the PSP of any changes to my account.

If elected, you will receive an AxisPlus MasterCard debit card, issued by Benefit Bank, and agree to use it according to the Cardholder Agreement that will be provided to you with the Card. You understand that the Card is to be used exclusively for qualified expenses as defined by the plan(s) in which you participate. If the card is used for non-qualified expenses, you are indebted to your employer and must repay the full ineligible amount. You agree to save all supporting documentation for payments made with the Card and to provide copies of that documentation to AxisPlus Benefits upon request. Failure to do so will cause the payment to be treated as a non-qualified expense.

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