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ELECTION FORM FOR THE FLEXIBLE BENEFIT PLAN

Employer _____ Employee Name _____

Social Security # _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ E-mail (Required for Debit Card to be issued) _____

Spouse's or Dependent's Full Name (for an extra FSA Debit Card) _____
(must be qualified dependent under IRS rules and regulations.)

Do you want to receive a FSA Debit Card to pay for your qualified expenses under Section 125 of the IRS Code?

IF YES, PLEASE CHECK BELOW AND INITIAL HERE _____

YES I want to elect the FSA Debit Card to pay for qualified expenses, and I understand that the annual fee is paid by my employer and includes one extra card for my spouse or a dependent. **NOTE:** By electing to receive the FSA Debit Card under my Plan and by signing below, I agree to use the Debit Card for only qualified medical expenses. I understand that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I also understand that if a payment is made that is not for qualified expenses under IRS guidelines, I will repay the Plan. I also understand that I am responsible for submitting all requested receipts to BMS to validate my card usage as required under IRS guidelines. Usage of the Debit Card at a qualified merchant does not negate the need to submit receipts per current IRS rules and regulations. I agree to review my account online at www.bmsllc.net to obtain information on open transactions that are in need of substantiation. Also, the debit card agreement that is sent to me with my card outlines the individual participant's responsibility for proper use. A valid e-mail address is a requirement for the card to be issued.

NO At this time, I do not want to use the Take Care debit card for the convenience of paying qualified expenses out of the plan(s) for which I am enrolling. I understand that, at a later date, I may opt to order a card online at www.bmsllc.net and will adhere to the guidelines outlined above.

OPTION **1** HEALTH CARE FLEXIBLE SPENDING ACCOUNT AGREEMENT

YES I elect to contribute \$_____ (before taxes) for the PLAN YEAR, which is \$_____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays qualified out-of-pocket healthcare expenses not covered by my health and other insurance plans. The Plan Year Maximum is set by the employer – please confirm with them prior to completion.

NO I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION **2** DEPENDENT CARE ASSISTANCE PLAN

YES I elect to contribute \$_____ (before taxes) for the PLAN YEAR, which is \$_____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays qualified dependent care expenses. Maximum amount per calendar year is the lesser of: (1) \$5,000 for married filing jointly or \$2,500 if married filing separate, (2) your spouse's total annual compensation or (3) half of your total annual compensation. If you are single, the maximum amount is \$5,000.

NO I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION **3** AGREEMENTS TO SAVE TAXES ON INSURANCE PREMIUMS

YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i. e. health insurance.) I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as participant.

My employer and I agree that my taxable income will be reduced during the year by an equal portion of the benefit elections (1-3) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election only in the event of certain changes in my status and that, prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I can review the Summary Plan Description available through my Employer. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: _____ Date _____

TO BE COMPLETED BY EMPLOYER	Plan year start (mm/dd/yy) ____/____/____ and end ____/____/____
	First payroll start date ____/____/____ Pay Cycle _____
8/07 version	