BMS LLC
BENEFIT MARKETING SOLUTIONS

P.O. Box 43653 Louisville, KY 40253-0653 **(502) 244-1161 (800) 919-BMSI FAX (502) 244-1162** ***www.bmsllc.net***

ELECTION FORM FOR THE FLEXIBLE BENEFIT PLAN-**DCAP Only**

Employer_____ Employee Name _____

Social Security # _____ Date of Birth _____

Mailing Address _____City _____State_____Zip_____

Home Phone (_____)_____E-mail Address_____

OPTION 1 DEPENDENT CARE ASSISTANCE PLAN (Dependent Care FSA)

☐ **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 2 AGREEMENTS TO SAVE TAXES ON INSURANCE PREMIUMS

☐ **YES** On the appropriate benefit enrollment forms, I have enrolled in certain employer-sponsored insurance benefits (i. e. health, dental, vision insurance and other qualified pre-tax benefits.) 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 a 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

Effective Date of Participation (mm/dd/yy) _____/_____/_____ and end _____/_____/_____
First payroll start date _____/____/_____ Pay Cycle _____

10/09 version