

FLEXIBLE BENEFITS PLAN ELECTION FORM

PLAN INFORMATION

EMPLOYER NAME: **COLORADO COLLEGE**

PLAN YEAR: _____

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

EMPLOYEE NAME

LAST _____ FIRST _____ MI _____

EMPLOYEE HOME ADDRESS

NUMBER AND STREET _____ CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ / _____ / _____

EMPLOYEE E-MAIL ADDRESS _____

EMPLOYEE TELEPHONE # _____ EFFECTIVE DATE OF PLAN _____

SPOUSE INFORMATION

Yes, please issue an additional *MBI Benefits Card™* to my legal spouse at no charge.¹

SPOUSE FIRST NAME _____ SPOUSE MI _____ SPOUSE LAST NAME _____ SPOUSE SOCIAL SECURITY NUMBER _____

ELECTION INFORMATION

I understand that the rules of the Internal Revenue Code allow me to use part of my salary on a pre-tax basis to purchase one or more of the following qualified benefits. I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below.

PLEASE CHECK YOUR ELECTION(S) AND FILL IN AMOUNT IF APPLICABLE

BENEFIT ELECTION OPTIONS

ELECTION

DEDUCTION

OPTION 1

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

YES

\$ _____ \$ _____
PER SEMI-MONTHLY PAY PERIOD ANNUAL

You can elect a maximum of **\$6,000.00** per Plan Year.
You can elect a minimum of \$5.00 per pay period.

____ I am paid 24 pay periods a year
____ I am paid less than 24 pay periods a year

OPTION 2

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCA)

YES

\$ _____ \$ _____
PER SEMI-MONTHLY PAY PERIOD ANNUAL

Maximum of **\$5,000** per Plan Year if single parent or if married and filing a joint return. Maximum of \$2,500 if married and filing separately.

____ I am paid 24 pay periods a year
____ I am paid less than 24 pay periods a year

My dependent care is through the CC Children's Center
Separate enrollment form required – DO NOT COMPLETE THIS FORM FOR DCA

I have reviewed and understand the terms and conditions on the back of this page and in my company's Summary Plan Description. I understand that I can not change or revoke this election at any time during the Plan Year unless I have a Change in Status change (including marriage, divorce, death, birth or adoption of a child, change or termination of spouse's employment, change in dependent care provider or such other events as the Plan Sponsor determines will permit a change or revocation of an election). I further acknowledge that I am responsible for keeping all receipts verifying all eligible expense claimed under my employer's Flexible Spending Plan and must submit such receipts to Planned Benefit Systems, Inc. for claims substantiation upon request.

YES, the benefits of this Plan have been explained to me and I elect to participate as indicated above.

Participant's Signature: _____

Date: _____

TERMS AND CONDITIONS

¹ **Spousal Card Request:** By providing spousal information and signing the enrollment form you authorize and understand the one additional MBI Benefits Card will be issued under your flexible spending account. Card will only be issued to *legal* spouse as defined by IRS(c) 152. Use of the card will directly affect your account balance. You are fully responsible to ensure that your spouse complies with the rules and regulations regarding the use of the card as outlined in the cardholder agreement to which you agree to be bound.

Qualifying Medical Care and Dependent Care Expenses: I understand that reimbursement will be available only for “qualifying medical care expenses as listed under Section 213 and “qualifying dependent care expenses” as listed under Sections 129 and 21 of the Internal Revenue Code for me and my eligible dependents. These expenses **must be incurred while I am enrolled in the Plan**. I agree to notify the Plan Sponsor or Planned Benefit Systems, Inc. if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to repay the Plan on demand by way of check or payroll deduction for any expense for which I have paid for with either the *Flex Convenience*® card or have received a check from Planned Benefit Systems, Inc. that is not allowed under Sections 213, 129 or 21 of the Internal Revenue Code. I attest that I understand claimed medical expenses can not be reimbursed under the Health Care FSA Plan if the expense has been or will be paid in the future by any other plan and **acknowledge that the medical expenses have not been reimbursed or are not reimbursable under any other insurance plan coverage**. I further acknowledge that I am responsible for keeping all receipts, verifying all eligible expenses claimed under the Plan, and must submit such receipts to Planned Benefit Systems, Inc. for claims substantiation as required.

Participation Rules: I understand that reimbursement account eligibility; enrollment and benefits information is available from my Plan Sponsor. I authorize payroll deductions for the benefit elections indicated on this Election Form. **I understand that I cannot change or revoke this compensation reduction agreement at any time during the Plan Year except for the occurrence of a Change in Status. In case of a Change in Status, I must complete a Change Form no later than 30 days after the date of the Change in Status occurs if I want to enroll in a reimbursement account or change my reimbursement account elections or amounts.** Any amounts remaining in the account(s) represented by this Election Form at the end of the Plan Year, past the claims filing limit will be forfeited to the Plan under the guidelines of the Internal Revenue Code. Expenses incurred prior to my plan enrollment date are not eligible for reimbursement.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE PLAN SPONSOR'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT; SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS; SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).