Preferred Health Plan
of the Carolinas

Flexible Spending Account Election Form and Compensation Redirection Agreement

Employee Name: _____ SSN_____
Last First MI
Employee Address: _____ Birth Date _____/_____/_____
Street Apt # MM DD YY
_____ ❑Married ❑Single
City State Zip ❑Male ❑Female

(Required) Email Address: _____
Work Phone (_____) _____ - _____ Home Phone (____) _____ - _____

Complete only if a debit card is to be issued for dependent over the age of 18.

Full Name	Birth date	SSN	Relationship
Spouse			
Dependent			
Dependent			
Dependent			

Plan Year:

✓ Check correct response: ❑ Open Enrollment ❑ New Enrollment ❑Enrollment Change_____

Amount of compensation redirected for the plan year:

❑ **Health Care Reimbursements**	Maximum of **$** for the plan year to be deducted in equal amounts from my pay checks.	Annual Election $	Deduction per pay check $
❑ **Dependent Care Assistance**	Not to exceed **$5,000** if you are married filing a joint return or you are single head of household, or **$2,500** if you are married filing separate returns for the plan year to be deducted in equal amounts from my pay checks.	Annual Election $	Deduction per pay check $

Effective date of contract: or effective date of change _____ / _____ / _____	Date of first deduction: Deductions will be taken from __ paychecks.

As an eligible participant in the **Flexible Spending Account Program**, I acknowledge that I have received the Summary Plan Description and the Flexible Spending Account Enrollment packet. I have read the Summary Plan Description, and the Flexible Spending Account Enrollment Packet, and understand the benefits available to me as well as the other rights and obligations I have under the Plan. In accordance with my rights under the Plan, I elect the above benefits and designate the above amounts for each benefit I have selected. The Employer and I hereby agree that my cash compensation will be redirected by the amounts set forth above for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

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I understand that:

1. Reimbursement will be available only for "qualifying expenses" as described in the Summary Plan Description, Flexible Spending Account Enrollment Packet, and allowed by the Internal Revenue Code. I agree to notify the Employer if I have reason to believe that any expenses for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security taxes from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.
2. This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.

DESIGNATION OF BENEFICIARY

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file the claims and seek the payment of benefits under the terms of the Plan. I therefore, designate as my beneficiary under the Plan:

Name: _____ Relationship_____

Address: _____

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke this compensation redirection at any time during the plan year unless I have a change in family status, (including marriage, divorce or legal separation, death of a spouse or child, birth or adoption of a child, dependent ceasing to be a dependent, termination spouse's employment, change in employment status, or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The redirection of my cash compensation under this Agreement shall be in addition to any redirections under other agreements or benefit plans.
- The amount of my compensation redirection for each pay period during the year will be credited to a appropriate account and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the year.
- Any amounts which are not used during the plan year to provide the benefits elected will be forfeited and may not be paid in cash or used to provide benefits specifically for me in a later plan year.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year. I understand I will need to complete and return a new election form at that time.
- My Social Security benefits, if any, may be reduced as a result of my elections.
- Premature termination of this agreement will result in the forfeiture of any remaining unreimbursed funds that were contributed up until the date of the termination. There will be a brief grace period of ninety days, which will begin the date the agreement is terminated, in which to request reimbursement for any expenses incurred within this plan year and prior to the date of termination. Expenses incurred outside of those dates are not eligible for reimbursement. After this grace period expires any remaining funds are considered forfeited.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE COMPANY'S MEDICAL REIMBURSEMENT AND/OR DEPENDENT CHILD CARE ASSISTANCE PLANS AS AMENDED FROM TIME TO TIME AND 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 REDIRECTION AGREEMENT RELATING TO SUCH PLAN(S). I HAVE READ AND UNDERSTAND THE TERMS OF THESE PLANS.

✍Employee's Signature_____ Date: _____/_____/_____

✍Accepted and agreed to by the Employer's Authorized Personnel:

BY: _____ Date: _____/_____/_____

Plan administered by:
PREFERRED HEALTH PLAN of the CAROLINAS
PO Box 749, Matthews, NC 28106
(704) 847-2321 ext 305, (866) 636-0239 ext 305
(704)847-3014 fax