myCAFETERIAPLAN®.com

a division of BusinessPlans Inc.

EMPLOYEE INFORMATION: ***(Completed by Employee)***			**ENROLLMENT INFORMATION:** ***(Completed by HR)***	
Name:			Date of Plan Entry:	
Email:			Date of First Payroll Deduction:	
SSN:			Assigned Payroll Schedule:	
Address:			Total Number of Pay Periods:	
City:	Date of Hire:			MED / DEP
State:	Zip Code:		Verified Per Pay Contribution:	/
Daytime Phone: ( )	Date of Birth:		Verified Annual Election:	/

I authorize my employer to make the following salary reductions: *Indicate below the options in which you would like to participate.*

Healthcare Reimbursement Account:*

1. *Deductibles and Co-pays*
2. *Eye Exams and Glasses*
3. *Prescription Drugs*
4. *Non-cosmetic Dental Procedures*
5. *Vitamins and Supplements* ***are not eligible***

Please visit* ***www.myCafeteriaPlan.com* *for a list of eligible expenses.*

A. Total Per Pay contribution:	**A.**	$
B. Total number of pay periods in plan year:	**B.**	
C. Total Annual Election: *Line A multiplied by line B* ***(Maximum allowed:)***	**C.**	$

Dependent Daycare Reimbursement Account:

1. *If married, your spouse must also be employed*
2. *Age limit for dependent children: 12 years of age*
3. *May be used for elderly care if they meet the dependent requirement as defined by the IRS*
4. *Maximum Allowed: $5,000 if single or married filing jointly, $2500 if married filing separately*
5. *Dependent must reside in your household the majority of the year*
6. *Tuition expenses for K-12 school* ***are not eligible***

D. Total Per Pay contribution:	**D.**	$
E. Total number of pay periods in plan year:	**E.**	
F. Total Annual Election: *Line D multiplied by line E* ***(Maximum allowed: See #4 above)***	**F.**	$

I understand that:

I cannot change this election during the plan year unless I have a change in status as defined by the Internal Revenue Code and Regulations.

Any amount remaining in my reimbursement accounts at the end of the year will be forfeited.

My Social Security benefits may be reduced by this election.

This election replaces any previous elections and will terminate on the earlier of:

(1) the end of the plan year.

(2) when I am no longer being paid compensation in an amount at least equal to my total salary reduction.

(3) termination of the plan.

(4) termination of employment.

My Employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I am required to keep sufficient documentation (e.g., invoices and receipts) for all expenses and may be asked to submit such documents to myCafeteriaPlan.

I hereby authorize my employer to payroll deduct any amount equal to the total of all unsubstantiated flex card transactions as reported by myCafeteriaPlan.

Signature: ______________________ Date: ____________

Please return your completed form to your Human Resources Department