Election Form

For answers to questions, contact the Region I Flex Department

218-236-2990 ● 800-450-2990

Plan Year	Group #	Plan Year Begin Date	Plan Year End Date

Last Name	First Name

Address	City	State	Zip

Employee ID #	E-mail Address

This election form revokes any prior election form, and will remain in effect and cannot be revoked or changed during the plan year, unless there has been a change in status.

PREMIUM CONVERSION

GROUP INSURANCE SPONSORED BY YOUR EMPLOYER I understand that premiums for the eligible group insurance benefits that I am enrolled in will be withheld from my paychecks on a pre-tax basis and be used to pay the premiums for the group insurance benefits that I have elected. I understand that this request will remain in effect until such time I notify my employer in writing, prior to the beginning of a new Plan Year, to discontinue this pre-tax withholding option.	No annual election required
NON-GROUP INSURANCE PREMIUMS WITHHELD AND PAID BY YOUR EMPLOYER (e.g. Life Investors, AFLAC) I request to have the following amount withheld on a pre-tax basis from my salary for the plan year, divided over the paychecks which I receive during the plan year. I understand these amounts will be used to pay the premiums directly to the insurance provider for the non-group insurance benefits that I have elected. I do not have to file a claim for payment. I also understand that if I discontinue the policy during the plan year, the amounts will still be withheld from my paychecks and I will forfeit the amounts, unless the discontinuation of the policy is due to a change in status event. If I do not enter an amount, I do not want my premiums to be withheld on a pre-tax basis.	Enter your **annual** election amount for the plan year $ _____

FLEXIBLE SPENDING REIMBURSEMENT ACCOUNTS

I request to have the following amounts withheld on a pre-tax basis from my salary for the plan year, divided over the paychecks which I receive during the plan year. These amounts will be deposited in my flexible benefits account(s). If I do not enter an amount, I do not want that account this plan year.	Enter your **annual** election amount for the plan year
Medical Expense Reimbursement Account - ***Select One of Three Options***	
1. **Full Flex** – my spouse and I do not have Health Savings Accounts.	$ _____
2. **Full Flex for myself and dependants only, excluding spouse** - my spouse has a Health Savings Account.	$ _____
3. **Limited Scope Flex, vision and dental expenses only** - I and/or my spouse has a Health Savings Account.	$ _____
Dependent Care (Day Care) Reimbursement Account	$ _____
Private Insurance Reimbursement Account	$ _____

AUTHORIZATION:

- I understand any amounts remaining in my reimbursement accounts at the end of the year will be forfeited.
- I understand my social security benefits may be reduced by this election.
- I understand my employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.
- I authorize my employer to reduce my salary and make the pre-tax deduction for the Plan Year for the choices indicated above. I understand that the amounts deducted will be reimbursed to me upon incurring the qualified expenses during the plan year. The types of qualifying expenses and method of reimbursement are detailed in the plan document.
- I understand that this election may be changed only in the event of a change in status. This agreement is subject to the terms of your Employer's Flexible Benefits Plan, as amended from time to time, and revokes any prior election and redirection agreement relating to such plan(s).

Signature: _____ Date: _____

OFFICE USE :