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FSA – MEDICAL AND DEPENDENT CARE REIMBURSEMENT COMPENSATION REDUCTION AGREEMENT

Company Name

Plan Year_____

Name: _____ E-Mail: _____

Address: _____

City:_____ State:_____ Zip Code:_____

Social Security Number: _____ Date of Hire: _____ Effective Date: _____

Home phone: _____ Work phone: _____

Pay frequency:

☐ Weekly ☐ Semi-Monthly

☐ Bi-Weekly ☐ Monthly ☐ Other _____

I elect to have my compensation reduced by the following amount for medical and dependent care expenses. Any previous waiver of participation is hereby revoked.

Do you elect to participate in the **Medical Care** Expense Reimbursement account? ☐ Yes ☐ No

Annual Reduction in Pay: $_____

Do you elect to participate in the **Dependent Care** Expense Reimbursement account? ☐ Yes ☐ No

Annual Reduction in Pay: $_____

Do you want to order a benefits card associated with your account? Yes ☐ No ☐

There is no card setup, maintenance, or standard mailing fee. A $15 charge will be assessed for lost or stolen cards that need to be cancelled and reissued. A $40 expedited shipping charge is applicable if rush shipping is selected. If you wish to have a separate card issued for a dependent, a $2 per card fee applies. To order a card for a dependent, please e-mail fsa@rpgconsultants.com and include in the e-mail the dependent's Name, DOB, SSN, gender, and his or her relationship to you.

- I understand that my compensation each pay period will be reduced by the total amount above divided by the number of pay periods in the year (or remaining in the year if you are becoming a participant at any time except at the beginning of the Plan Year).
- I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next January 1st, unless I have a change in family status (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Administrator determines will permit a change or revocation of an election).
- Prior to January 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new Election Form at that time, I will be treated as having elected cash instead of salary reduction for the new Plan Year (January 1st to December 31st).
- The Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the provisions of the Plan if it is believed to be advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.
- This benefit election will automatically be cancelled as of the date of my termination of employment. However, if you continue to be covered under the Employer's medical plan or plans, you may be able to continue participation in this plan during your period of coverage. You will receive information on this option when you terminate service.

Employee's signature: _____ Date: _____

Employer's signature: _____ Date: _____