CHOICES, the Montana University System Employee Benefits Plan
OPTIONAL REIMBURSEMENT ACCOUNTS (FLEX ACCOUNTS)
ELECTION AND COMPENSATION REDUCTION AGREEMENT FORM

Check reason you are completing this form: ☐ New Plan Year Enrollment ☐ Mid-Year Change

Campus or Employer: _____ PLAN YEAR: July 1, 20____ through June 30, 20____

**** Please note there is a $2.50 monthly admin fee** Effective Date: _____

Employee Information

Name (Last,First, MI): _____ Social Security Number: _____

Address: _____ City, State, Zip: _____

Phone: Home: (____) _____ Birth Date: _____

Work: (____) _____ Enrollment Status: ☐ Married ☐ Single

Gender: ☐ Male ☐ Female Email Address:** _____

Number of Pay Checks in Plan Year (circle one): Biweekly: (24 + 2 free) (26) Monthly: (10) (12)

** Claims processing notification sent to your email address Specify Other: _____

As an eligible employee in the MUS Benefits Plan, I acknowledge that I have received or been given internet access to the Summary Plan Description (http://mus.edu/choices/fsa.asp "Review your medical and dependent care Summary Plan Description") and understand the benefits available to me as well as other rights and obligations which I have under the Plan. I understand that I will automatically participate in the insurance premium expense account (and MUS premiums are deducted tax-free from payroll) unless during the election period I provide written notice that I do not wish to participate. In accordance with my rights under the Plan, I elect the following Flex benefits and designate the following amounts for each Flex benefit I have selected for the Plan Year specified below. The Employer and I agree that my *cash compensation*** will be reduces by the amount set forth below for each pay period in the Plan Year (or during such portion of the year remaining after the date of this agreement, or as prorated to accommodate the terms of my contract), to the extent that the Employer's contribution (State Share) does not cover my Flex account election.

Benefit Elections (managed by Flex Connect)

In accordance with my rights under the Plan, I elect the following Flex benefits and agree that my compensation will be reduced by the amount set forth below. I understand and agree that my compensation will also be reduced by the amount of the premiums for the employer sponsored group insurance programs in which I have elected to participate.

	Total Annual Election for the Plan Year (Elections must divide evenly by 12.)	**Total Pre-Tax Monthly Election**	**Check if Mid-year Change***
Health Flexible Spending Account	_____ (maximum $2,500.00/yr.)	_____	☐
Dependent Care Account	_____ (maximum $5,000.00/yr.)	_____	☐
Adoption Assistance	_____ (maximum $12,650.00/per child lifetime)	_____	☐
Health Insurance Premium Reimbursement (working under a post-retirement contract. Group coverage is NOT eligible, including Medicare Parts B, C, or D. **Preapproval by campus office is required.**)	_____	_____	☐
TOTALS:	_____ Total Annual Deductions	_____ Total Monthly Deductions	

Each election must be at least $120.00 (12 x $10.00/month).

If this election is a change, please attach a Change in Status form.

This agreement is subject to the terms of the Employer's Flexible Spending Plan currently in effect, as amended from time to time; 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.

_____ _____

Employee's Signature: Date

_____ _____

Accepted and agreed to by the Employer's authorized representative Date

**NOTE: Reduction of *cash compensation* will result in lower contributions paid to and less income reported to Social Security and Medicare, which may reduce the amount of those benefits to the employee in the future.

ELECTION FOR INSURED BENEFITS

As an enrollee in Choices insurance plans, my premiums will be automatically withheld on a pre-tax basis unless during the election period I provide notice in writing that I do not wish to participate on a pre-tax basis. I understand that if my required contributions to pay premiums are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease. If I elect to be covered under disability insurance through the Plan, any benefits paid to me from such insurance will be fully taxable to me and it will be my responsibility to include these amounts in my gross income for tax purposes.

ELECTION OF HEALTH FLEXIBLE SPENDING

The annual Plan limit which may be allocated to the health flexible spending account is $2,500. I understand that reimbursements will be available only for "qualifying medical care expenses". Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my federal income tax return (without regard to the adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense 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 or Medicare tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax I owe.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued. If I cease my employment with the Employer, my participation in the Health Flexible Spending Account will either cease or continue at my election. If I elect to continue, my salary redirections will continue with after-tax contributions for the remainder of the Plan Year unless prepaid with pre-tax funds from my final paycheck. If I incur a change in family status, I may change the amount I have directed towards my Health Flexible Spending Account. I cannot seek reimbursement from this account for a medical expense which I intend to claim as a deduction on my tax return.

ELECTION OF DEPENDENT CARE ASSISTANCE

The annual Plan limit which may be allocated to the dependent care flexible spending account may not exceed the least of: (a) $5,000.00 ($2,500.00 if you are married filing separate returns); (b) your taxable compensation; or (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a deemed monthly earned income of $250 for one dependent or $500 for two or more dependents). I understand that reimbursement will be available only for "qualifying dependent care assistance expenses" as described in Internal Revenue Code Section 129, the Plan Document and the Summary Plan Description. I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred. I agree to provide the Administrator with the name, address and, if applicable, the taxpayer identification number of the service provider. I agree to notify the Employer if I have reason to believe that any expense 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 or Medicare tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax I owe.
This section of the agreement will automatically terminate if the Plan is terminated or discontinued. If I cease my employment with the Employer, all contributions to the dependent care flexible spending account will cease. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year. I will only be reimbursed for amounts up to the balance in my account at the time of my request. I cannot claim a dependent care tax credit for amounts I receive as reimbursements under this dependent care assistance program.

ELECTION OF ADOPTION ASSISTANCE FLEXIBLE SPENDING

The annual Plan limit which may be allocated to the adoption assistance flexible spending account is $12,650. I understand that reimbursements will be available only for “qualifying adoption expenses” as described in Internal Revenue Code Section 137. I agree to notify my Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse my Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive on a non-qualifying adoption expense, up to the amount of additional tax actually owed by me. This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year. I will only be reimbursed for amounts up to the balance in my account at the time of my requcommo

PREMIUM REIMBURSEMENT

Employees with outside insurance coverage which qualifies under *Choices* , the Montana University System’s Employee Benefits Plan, may elect to pay those premiums with pre-tax salary reductions. Eligible insurance may include individual health or disability insurance policies. No group coverage premiums, including spousal employer premiums or any Medicare premiums, are allowed.

I understand that I must furnish adequate proof of this coverage and that approval for policy eligibility must be obtained from the Montana University System and FlexConnect prior to the election form being approved.

If required contributions to pay premiums to a third party insurance company are increased or decreased during the Plan Year, I may submit a change in status request and revised election form requesting approval of the increase or decrease to the Premium Reimbursement spending account election.

OTHER TERMS AND CONDITIONS

I understand that I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year unless I have an allowable change in status, and my election must be consistent with such change. The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my employer. **Any deductions elected with this form that are not used during the Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year. Claims for reimbursements must be filed on or before September 30th following the end of the 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. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my insured benefit elections then in effect for the new Plan Year but not my non-insured benefits (ie: Flex Plan benefits).